N.Z. Board Hlth. Rep. Ser., 1973 18

BOARD OF HEALTH
REPORT SERIES: No 18

DRUG DEPENDENCY AND DRUG ABUSE IN NEW ZEALAND

(SECOND REPORT)

WELLINGTON 1973

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(d) The co-ordination of the activities of local authorities under this Act and of the activities of voluntary associations in respect of public health, with the activities of the Department of Health.

To Professor Paton
With the authors' compliments

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SECOND REPORT

Opinions expressed in this report are those of the committee responsible and do not necessarily represent the views of the Board of Health

Published 1973

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1. THE WORK OF THE COMMITTEE 1970–72

1.1 In February 1970 this committee, set up by the Board of Health to inquire into drug abuse and drug dependency in New Zealand, saw the release of its first report. Initially 10,000 copies were distributed to professional organisations responsible for the licit prescribing, dispensing, and distribution of drugs, to church and welfare organisations, the libraries of educational establishments and public libraries, to all members of Parilament, to the courts and to law enforcement agencies, and to services, organisations, and Government departments whose interests or responsibilities brought them in any way into contact with problems involving drug misuse. The report was also distributed to New Zealand posts overseas, to the health administrations of all Commonwealth countries, to the World Health Organisation and other United Nations agencies, and to the missions of countries having representation in Wellington. It was soon found necessary to authorise a further printing of 2,000 copies to meet the very heavy demand from within New Zealand and overseas. Subsequently, a further run enabled copies to be made available on sale through Government bookshops.

1.2 The primary objectives of the committee in its first report were to trace the history and course of drug abuse and drug dependency in New Zealand, to delineate the extent of the problem at the time of publication, to relate this to corresponding situations elsewhere, and to direct attention by way of specific recommendations to those areas in which we felt that remedial action could be most usefully directed in the first instance. In other words, we sought to establish a baseline from which any subsequent developments could be more readily observed and the need for further remedial action in the broad fields of health education, treatment, rehabilitation, and legislation more effectively determined. In April 1970 the Board of Health, recognising the rapidly changing nature of the drug scene, resolved that the committee should continue its inquiry and embody its findings in a second report.

1.3 Since April 1970 the committee has met on 38 full days, of which 33 were in Wellington, 2 in Auckland, 1 in Christchurch, and 2 in Dunedin. In addition, on quite a number of occasions one or more members of the committee have met interested parties, users, and organisations for the purposes of its inquiry or taking further evidence in Auckland, Wellington, and Dunedin. Wellington members met on 12 occasions for drafting the report.

1.4 The adviser to the committee, Mr J. I. Ashforth, attended both the United Nations Convention on Psychotropic Substances (Vienna, 1971) and the United Nations Conference to review the Single Convention on Narcotics Drugs at Geneva in 1972.

1.5 Professor A. J. Metge, on her own initiative, spent a not inconsiderable part of her 1970–71 sabbatical leave in a study of aspects of the drug scene in North America, where she met members of the Le Dain Commission, and in the United Kingdom, where she visited a number of treatment facilities in the Greater London area.

1.6 Mr R. J. Walton, O.B.E., whilst overseas in the course of his police duties, also had opportunities to observe some aspects of the drug scene in the United Kingdom and parts of Europe and the Middle East.

1.7 On the research side, Professor F. N. Fastier, while on sabbatical leave and when attending a WHO Regional Seminar, had consultations with United Kingdom Home Office and pharmacologists in England and Manila.

1.8 The chairman has conferred with directors of health and representatives of Government and research organisations in the South Pacific Commission area on several occasions and has presented two papers as a basis for discussion. In addition, the Department of Health made it possible for the Auckland medical officer of health to visit a number of centres in London concerned with the treatment and rehabilitation of drug misusers, including several of the facilities and persons visited earlier by Professor Metge.

1.9 On reconvening in 1970 the committee accorded some priority to gaining a fuller understanding of the current ferment of interest in the non-medical use of drugs generally and in the marijuana issue in particular among university and other tertiary education students and those associating closely with them. To this end it invited the New Zealand University Students Association, individual university student associations, their counterparts in teachers colleges, and some other bodies to make submissions and to appoint representatives to present these submissions to the committee if they so desired. The response from the university groups especially was most encouraging and a great deal of thought, care, and time had clearly been put into preparation of the submissions, two being outstanding in content and presentation among all those we received. The ensuing dialogues greatly increased the committee's understanding of the attitudes and concerns behind the views expressed and their emphases.

1.10 While the marijuana issue continued to occupy the forefront of student submissions, some of the assertions made and arguments made earlier had been modified in the light of recent literature including the first report to produce on the whole, well balanced assessments. The committee received the impression of a greater awareness of the dangers of cannabis resin and the active principles that may be derived from cannabis but noted with some concern that there was still a tendency to claim that less-stringent criteria should be accepted in determining safety standards in the case of cannabis than those mandatory for the release of new therapeutic drugs. It noted also an unwillingness to admit the substantial dangers of LSD which the United Nations Convention on Psychotropic Substances placed in a category requiring control as stringent as heroin. However, in all cases welcome recognition was given to the dangers to both the individual and the community of trafficking and of the unrestricted use of the so-called "hard" drugs.

1.11 Between 1970 and 1971 the work of the committee was interrupted to allow several of its members to participate in the three national seminars held at Christchurch, Wellington, and Auckland in implementation of recommendation 12 of the committee's first report. A summary of the seminar proceedings and a list of those taking part is to be found in appendix XVI. The seminars afforded an opportunity early in the current phase of the committee's work for the better identification of those areas to which it could most profitably direct its attention. In view of the similarity of the material and questions presented to the three successive seminars, it was decided that the

proceedings would not be open to the press. In consequence, such differences as did emerge at the three meetings can be taken with more assurance as reflecting the wider community attitudes in each of the three centres. A press conference was, however, held in Wellington concerning the aims of the seminars.

1.12 In 1971 and 1972 the committee directed its attention primarily to three tasks: a review of the existing legislation; a study of the situation and needs of the persons who misuse drugs, with special reference to assessment, treatment, and rehabilitation; and consideration of the health education needs of the communuity. We also read and discussed with interest the findings of important United Nations conferences and national commissions and committees, especially in the United States, United Kingdom, Canada, and Australia, and looked further into certain aspects of the legal distribution of drugs, notably prescribing, the education of doctors and pharmaceutical advertising. These concerns are reflected in the layout and presentation of this report, as a glance at the list of Section headings will confirm.

1.13 Many of those who made submissions to the committee displayed considerable concern and some misunderstanding about the supposed severity of existing penalities under the Narcotics and Poisons Acts and also about a presumed lack of attention on the part of the courts to the offender's need for medical or psychiatric assessment, treatment, or rehabilitaton. To meet this concern, the committee has included in section 4.38 to 4.42 a much fuller survey of the existing legislation than was given in the first report together with a comparison of its penalties with those obtaining in a variety of countries overseas. It also arranged for a study to be made of the penalties actually imposed for drug offences in New Zealand courts in 1969 and 1971. This was made possible by the co-operation of the Department of Health, which appointed a temporary research assistant for the purpose, and also that of the Justice and Police Departments which allowed the research assistant confidential access to court and departmental records. Finally the committee itself undertook, as it had long intended to do, a study of what the legal philosophers have to say about the nature and purposes of the criminal law and especially the extent to which it can justifiably be used to interfere with the freedom of the individual to misuse drugs, when he, himself, is the only apparent victim. In this connection, committee members studied the ably expounded dialogue between Sir Patrick Devlin and Professor Hart and various commentaries on it, sought the advice of several New Zealand legal authorities, notably Mr D. L. Mathieson, formerly Professor of Jurisprudence at Victoria University of Wellington, and profited from the exposition of the problem by the Le Dain Commission in their interim and cannabis reports. It also heard at first hand the philosophy underlying the United States National Commission on Marihuana and Drug Abuse first report. The committee apreciates the invitation to its chairman to become a consultant to the commission.

1.14 Since the publication of our first report, two important United Nations conferences have formulated a new Convention on Psychotropic Substances and have revised the Single Convention on Narcotic Drugs. As both the new Convention and the revised Single Convention will involve some changes in the New Zealand legislation

these important conventions are referred to in some detail in section 4.90 to 4.92 and in appendix VIII. The committee was particularly fortunate in having Mr J. I. Ashforth, who was the New Zealand delegate to both conferences, as its adviser.

1.15.1 During the same period a number of important reports have been published by overseas commissions and by committees of UNESCO and WHO. These include three from the Advisory Committee on Drug Dependence in the United Kingdom (the Treatment of Drug Addicts, the Amphetamines and Lysergic Acid Diethylamide (LSD), and Powers of Arrest and Search in Relation to Drug Offences), three from the Canadian (Le Dain) Commission of Enquiry into the Non-medical Use of Drugs (the Interim Report 1969, Cannabis, and Treatment, the report of the Australian Senate Select Committee on Drug Trafficking and Drug Abuse, the first report of the National Commission on Marihuana and Drug Abuse appointed by the United States Congress—*Marihuana: A Signal of Misunderstanding.*

1.15.2 Committee members have studied and discussed these reports at length and referred to them frequently in writing this second report. In particular the committee is impressed by and fully endorses the attenion given in all these writings to the persons involved in drug misuse as opposed to the drugs in and of themselves; to consideration of the social and economic background and the community attitudes which influence drug usage; and to the devising of more effective forms of treatment, health education, and alternatives to drugs.

1.16 Studying these recent reports led us to take another look at some earlier classics, the evidence submitted to the Indian Hemp Commission 1894 (or strictly speaking those parts of it available to us), the La Guardia report (1938–44) and the report on Cannabis (widely known as the Wootton report) prepared by a subcommittee of the United Kingdom Advisory Committee on Drug Dependency (1969).

1.17 In June 1972 a special meeting of the committee was called to meet Governor R. P. Shafer, Chairman of the United States National Commission on Marihuana and Drug Abuse (which produced one of the reports just mentioned), together with the Executive Director, Mr Michael R. Sonnenreich, and two members of the commission, Professor Maurice H. Seevers, a world authority in pharmacology, and Dr J. Thomas Ungerleider, a psychiatrist. This meeting afforded an excellent opportunity for elucidation of the philosophy underlying the report and recommendations of this distinguished multi-disciplinary commission. In addition the chairman, two other members, and the committee's adviser had further quite lengthy discussions with Governor Shafer and his party while they were in Wellington. The committee notes, with regret, that, despite explicit statements by Governor Shafer in television and press interviews, it is still erroneously and perhaps wishfully believed and even publicised in some quarters in New Zealand that the United States National Commission favours the "legalisation" of marijuana, whereas in fact, the commission advocated a policy of firm discouragement of marijuana. Further reference is made to the United States National Commission's first report and two volume appendix of technical papers and relevant data in section 4.74.1 and appendix III.

1.18 With regard to the relevance of these overseas reports to the New Zealand situation, the committee rcognises that it is neither practical nor sensible to attempt to apply, unchanged, the measures recommended or applicable in one country to the differing social, legal, and administrative circumstances of another. Nevertheless, we have been impressed to discover the extent to which the various reports are in agreement on certain broad principles. We have accordingly included summaries of certain key issues and innovations from these reports where they are relevant and helpful to the New Zealand situation in appendix III.

1.19 In the first report, the committee insisted in several places that drug misuse should not be viewed as an isolated phenomenon but should be seen in its total social context. In particular we suggested that a significant amount of drug misuse was fostered by the general climate of acceptance of drugs in the community at large and especially by the permitted large-scale promotion of their use, whether prescribed by doctors or sold across the counter. Encouraged by widespread advertising and the ready availability of drugs in the shops or under social security (pharmaceutical benefits), too many people (we suggested) have become conditioned to expect or demand an instant chemical answer to every problem. The committee felt this issue to be of sufficient importance—and appreciation of it sufficiently limited—to warrant inclusion of further comments on it in this report, in section 5. It is a field in which detailed proof is difficult to produce. Our conclusions in the first report were based largely on the long experience and knowledge of the pharmacist, pharmacologist, and doctors working with the committee. We have since noted, with great interest, an unpublished study, made by Dr A. W. S. Thompson, in 1958, of the prescribing patterns of doctors with regard to hypnotics and the purposes and categories of patients for whom the hypnotics were most frequently prescribed by doctors or most persistently sought by certain patients. This particular study was made before the advent of a group of psychotropic drugs loosely described as "tranquillisers", which have firmly established their place in therapeutics, in the prescribing patterns of doctors, and in the esteem of many patients. While these tranquillisers are beyond all doubt appropriately used for their purpose and have proved their value, there are, even so, grounds for believing that their use and the demand for them may have already reached beyond real therapeutic needs. We, therefore, welcomed an offer by Dr Thompson to undertake a similar survey for the period of July 1971 to cover both the tranquillisers and hypnotics. We feel that the results are so valuable as a factual record of the situation and as a baseline for future studies that we have included the full text of the paper in appendix XII. Some further comments on it are included in section 5.10.

1.20.1 During 1972, and indeed during the drafting stages of the second report, the committee has been most concerned at a significant number of deaths—11 in Auckland and 3 in Christchurch—closely linked with misuse of narcotics prescribed by a very small group of practitioners having an extensive clientele of persons involved in drugs or actively seeking them. It has also noted with concern the findings of monitoring of narcotic prescribing by the Department of Health which revealed disturbing figures for "consumption" in three major centres,

as compared with comparable aggregations of population elsewhere in New Zealand. One of the smaller of the three centres referred to had nearly five times the "consumption" of the largest.

1.20.2 Further inquiries revealed that an incidental factor in this situation may well have been the form of promotional activities of the agency for the synthetic opiate responsible for much of the upsurge. (See also section 5.24.) A further factor common to all three centres was undoubtedly the extent to which there was inattention to the need for strict assessment of the extent of true dependence—if any—and on what drugs before a decision was made to prescribe a synthetic and dependency inducing narcotic for the purposes of substitution and treatment. Even more disturbing is the clear evidence confirmed by coroners inquests—that little regard was seemingly paid to the prudent criteria recommended in many overseas' reports which include a minimum age of 20 years below which substitute therapy with synthetic opiates is contra-indicated.

1.20.3 The committee welcomes initiatives by medical officers of health and some divisions of the Medical Association of New Zealand to confer with and advise practitioners who have directed attention to themselves in the course of monitoring of prescribing of narcotics. The committee recognises the need for amendment to the Narcotics Regulations to provide for better safeguards against departure from prudent practice in this field, and to safeguard the well-being—and, indeed, in some cases the *lives* of would-be or actual misusers.

1.21 The committee has considered, on a number of occasions, matters relating to the role, content, and delivery of health educational material relevant to drug use, both therapeutic and non-medical. The committee has noted with considerable interest the increasing emphasis being given to the role of education in a wide range of reports from national commissions, committees, and various organs of the United Nations special agencies, and of overseas departments of health. Various New Zealand welfare organisations, some linked with churches and others quite independent of any church or Government department connection, are likewise showing such interest. The committee has sought and received a substantial volume of educational material, currently or recently in use in many overseas countries and in New Zealand. This is reviewed in section 8 and provides the basis for our own comments, and recommendations regarding future developments in New Zealand are in section 9.

1.22 In July 1972 the chairman and the adviser to the committee and a majority of members had most welcome opportunities for discussions with Mr Carl Schurmann, personal representative of the Secretary-General of the United Nations, on the programme, purposes, and priority of projects which the United Nations Fund for Drug Abuse Control is currently funding in the triple fields of supply, demand, and trafficking. The high priorities being accorded to crop-substitution and other measures in the principal areas of opium production in Northern Thailand, Burma, and Laos (with agreement for such approaches in less-accessible parts of Afghanistan) and the emphasis given to utilising personnel for such projects able to appreciate and adapt to the conditions of the country in which the assistance is being given, have a special significance. The same may well be said

of the United Nations Fund's approach to the demand aspects, particularly a critical appraisal of the techniques of health education, many presentations of which, hitherto, have been lacking in impact or may even have been counter-productive. Similarly the need to study in depth the social and economic conditions, and community attitudes and expectations, in which drug misuse may either readily take root or fail to flourish are basic to the international as well as to the local scene (appendix VIII). During his Dunedin visit Mr Schurmann had discussion with several members of Otago University staff currently involved in drug research, including marijuana.

1.23 We welcome two actions of the Medical Research Council of New Zealand. The first was the setting up of an ad hoc committee to report on existing knowledge about cannabis with the object of seeing whether any research should be carried out in New Zealand. The second was the subsequent establishment of a standing committee on the non-medical use of drugs. Two of our members serve on the latter. Although the amount of research being undertaken here is necessarily small it can be a very useful supplement to that performed elsewhere because of certain national advantages, for example, the existence of a large proportion of individuals who can act as unsophisticated subjects and the ease of keeping in contact with individuals over long periods. From a national viewpoint it is also beneficial that some scientists should be acquiring a firsthand knowledge of the effects of cannabis. Further reference to research is to be found in section 7.

1.24.1 In submissions, interviews, and comments on the first report, a number of people have made critical mention of the virtual omission of any consideration of alcohol or tobacco from the first report. The committee accepts this as fair comment and regrets that it did not clearly enough set out the reasons for this omission. From its inception the committee has been unequivocally of the opinion that both alcohol and tobacco are drugs which can cause dependence and which are seriously misused in New Zealand. However, when we came to consider the size of the task we had been set—"to inquire into drug dependency and drug abuse in New Zealand"—it became apparent to us that we could not cover the whole field if we were to complete even a first report in a reasonable time. We, therefore, decided to exclude consideration of alcohol and tobacco for three reasons: first, because the study of their misuse is a vast topic in its own right, with a vast literature; secondly, because several such studies were already under way in New Zealand under the auspices of other bodies; and thirdly, because the recent upsurge in the misuse of other drugs demanded our immediate and concentrated attention.

1.24.2 In this second report, we have continued to concentrate our attention on the misuse of other drugs for the same reasons, making only brief reference to the topic in section 7. We should, however, like to make quite clear our recognition of the fact that the problems arising from the misuse of alcohol and tobacco are, at present, in many ways far greater and affect far more people than those involved in the misuse of the drugs with which this report is concerned. We did, in fact, make a comment to this effect in 5.55 of our first report, but so briefly that it has seemingly been overlooked by many readers, especially those for whom misuse of alcohol and certain forms of tobacco misuse are rightly matters of particular concern.

1.25 The committee is deeply indebted to the many persons and organisations whose names are listed in clear, or when they so requested, in code, as having tendered evidence in written or oral submissions, or both, at formal meetings of the committee. In a few cases such submissions were made to a group of committee members. The committee has made every endeavour to meet the convenience of all those who came forward. It is aware that in quite a number of instances the willingness to attend for the purpose of giving evidence has been at no little inconvenience to the persons or group concerned. The committee, therefore, wishes to record its very warm appreciation of the interest shown and trouble taken to assist the committee by presentation of personal observations, facts, findings of observation and research, personal experience in the case of user witnesses, and of various points of view.

1.26 As in its earlier workings the committee has attached particular importance to the experience, knowledge, viewpoint, and the insights or motivations of the individual user; and the way such users see themselves in relation to their own group and the community around them. It has likewise been much concerned with evidence and observations of persons closely associated with user groups of whom it is thought that collectively our user witnesses make up a fair cross-section of those involved.

1.27 The committee would like to record its appreciation of the very great interest taken by New Zealand missions abroad in ensuring that copies of many important recent reports were received by its secretary within a few days of their release. The committee also appreciates the attention given to supplying it with many matters of interest, innovation, or concern at Government, legislative, or regulatory level, and in the broad field of social welfare concerned with drug involvement in a number of countries. This interest has enabled committe members to draw some comparisons between the original text of overseas ministerial statements and press releases in the countries of origin and the form in which these have sometimes appeared in the New Zealand media. It recognises, nevertheless, the difficulties that face the media in reporting measures devised or philosophies expounded in terms of a different background and body of law.

1.28 The committee notes with appreciation the extraordinarily high sense of responsibility of the Pharmaceutical Society, the Chemists Guild, and the dispensing pharmacists and their whole-hearted co-operation in all matters relating to the detection and suppression of drug irregularities. Without this single-minded alertness to the dangers and consequences of drugs being used other than for licitly prescribed and medicinal purposes, and then only in sufficient quantities and for sufficient time as the needs may require, there would be far greater diversion from licit to illicit channels of distribution.

1.29 The committee also wishes to record its appreciation of the unique and sustained contributions made by its adviser, Mr Ivan Ashforth, to whose immense store of readily retrievable knowledge and experience and written contribution it owes so much.

1.30 It also places on record the appreciation of the work of Mrs Katherine Swift, both as secretary to the committee prior to 13 February 1971 and subsequently on her reappointment to the committee's staff on a part-time basis. Her successor, Mrs Eileen

Gosson, by her sustained enthusiasm and organisation of the committee's formal daytime and informal evening meetings in Wellington and other centres, has significantly assisted the work of the committee. The committee is also indebted to Mrs Gosson for close attention to detail during the protracted task of editing the second report.

1.31 The committee is especially appreciative of the contribution made by Mr D. L. Mathieson of the Crown Law Office towards a better understanding and presentation of some of the complex issues dealt with in section 4—Drugs and Law.

1.32 The committee also wishes to record its appreciation of the many cogent observations and constructive suggestions of Mr K. H. Digby, Office Solicitor, Department of Health, with regard to application of the several New Zealand Acts relating to the control of drugs and matters germane thereto.

2. SOME MATTERS OF DEFINITION

2.1 During the hearing of witnesses and in the course of its deliberations prior to drafting of the first report the committee was very much aware of the need to ensure that readers understood the sense in which it used certain terms and common expressions. It was, above all, anxious to avoid the difficulty for the reader which Lewis Carroll expressed through the mouth of Humpty Dumpty "When I use a word it means what I want it to mean". In the course of its workings since April 1970 the committee has become aware of a few more words and terms which seem to be used in quite widely differiing senses by some of the people who have made written or oral submissions. This has led the committee in turn, to review some definitions set out in section 2 of its first report; to add some further notes where it felt that the sense in which certain terms were used required further explanation or definition, and to make reference to some terms not included or sufficiently explained in section 2 of the first report.

Proper Use, Misuse, and Abuse

2.2 In the first report we defined "drug abuse" as "use outside accepted medical practice" associated with self-medication for non-medical purposes and "misuse" as largely synonymous with abuse but with the connotation of lesser harm to the individual" (2.4). In the body of the text, however, we tended to use "abuse" to identify use that was both non-medical and illegal, and "misuse" for the whole field of bad use, including bad medical yet legal use, as well as non-medical and illegal use. (See for instance 15.1.) The *Concise Oxford Dictionary* makes no real distinction between the two words, defining "misuse" as "to use wrongly, apply to wrong purpose" and "abuse" as "to misuse, to make bad use of". Both imply a clear value judgment. We now feel that the use of these terms with slightly different meanings was confusing and difficult to sustain. In this second report we give preference to the more general and less emotive term "misuse".

Drug Misuse

2.3.1 Drug misuse is a negative term, and its meaning can be defined only in terms of opposition to and departure from the concept of "good", "right", or "proper" use, in this case of drugs. This is a topic which tends to be taken for granted. We would like to stress its primary importance in all programmes of drug education and in discussions of "misuse". For the purposes of this report, we propose the following short summary definition: "the proper use of drugs involves either use under competent medical supervision or use in accord with the principles of healthy living and medical practice currently accepted and propounded by health and medical authorities". This definition allows for the fact that with continual evaluation of medical practice and new discoveries, the health and medical authorities may change their views on certain practices, as for instance they have done in recent years with regard to cigarette smoking of tobacco.

2.3.2 It should not be overlooked that misuse can and does occur within the limits of the law, for instance, when prescribed drugs are taken in quantities at times or by methods other than those directed

by the prescribing doctor, when drugs available for purchase without prescription are taken for purposes unsupportable on medical grounds, or when alcohol is taken in amounts that seriously impair a drinker's physical and social functioning.

2.3.3 New Zealand currently accepts as proper the use of a few drugs for non-medical purposes, notably alcohol, tobacco, and caffein, within the limits of certain legal controls on the one hand and certain social controls on the other. It becomes misuse, however, as soon as it contravenes either set of controls and begins to cause harm to the user or to others. We shall not, therefore, use the term "non-medical use of drugs" as a synonym or alternative for "drug abuse", as is sometimes done. When we wish to be specific about the type of misuse we will use the terms "legal misuse" and "illegal use".

2.3.4 The distinction between the legal and illegal use of drugs is a clear-cut one in terms of the current legislation, and particular cases are easily identified as one or the other. The boundaries between proper use and misuse, and between medical and non-medical use, are not nearly so well defined. Because judgments in the areas of values and professional expertise are involved and human motives are always mixed, there will inevitably be some differences of opinion as to where they should be drawn both in general and in particular cases. It can well be a matter of debate whether a particular person's use of sleeping pills or tranquillisers is justified on medical grounds, or whether another's use of alcohol has yet reached the stage of misuse. Before condemning those engaged in the illegal use of drugs out of hand, it behoves us all to take a careful look at our own drug use and to ask whether at least some of it may not come uncomfortably close to misuse.

2.3.5 Occasional misuse of drugs may, but does not necessarily, lead to the development of dependence. The occasional, or "binge" user, of alcohol or other drugs is certainly involved in misuse but may avoid developing dependence provided he escape or can resist the temptation to increase the frequency and scope of his indulgences.

Drug Dependence

2.4.1 The concept of drug dependence must be carefully distinguished from the concepts of proper use and misuse, both of which it cross-cuts. Drug dependence is a condition which develops when certain drugs are administered above a certain level of dosage over a variably critical period of time. It takes two forms, which may or may not occur together: physical dependence which results in certain unpleasant, objectively observable, physiological reactions (withdrawal symptoms) when the drug is stopped, and psychological dependence, which when the drug is stopped, gives rise to a form of psychological distress, which is much more difficult to assess, and even more difficult to overcome.

2.4.2 Drug dependence may develop in the context of medical as well as illegal administration. For instance, when a patient has been prescribed and has needed a morphine-type drug for pain relief for a long period he could be expected to exhibit some physiological withdrawal symptoms if it is stopped too abruptly when the cause of the pain is removed. However, such a patient does not usually develop psychological dependence on the opiate along with the physical dependence, and once the medical need for the drug is removed he normally

accepts its fairly rapid withdrawal without craving or complaint. On the other hand, when a drug is sought and taken for non-medical purposes outside medical supervision, psychological dependence is much more likely to develop in addition to or even in the absence of physical dependence and to become the greater problem, because of the very different aims and motivation of the self-administrator. Many misusers of drugs have been through successful withdrawal regimes several times, but the fact that their bodies no longer need the drug for physical comfort does not necessarily prevent their returning to it.

Management

2.5.1 In this report, particularly in the context of reference to treatment, the committee has taken the view that the word "treatment" was insufficient in itself to describe the nature and long duration of social, medical, and psychological remedial attentions aimed at reducing or hopefully abolishing dependence on narcotic or psychotropic drugs. Use of the term "treatment" alone to describe the remedial process is both unfortunate and misleading, for it tends to focus attention on just one or two aspects of what is a very involved process which calls for application of the resources of a multi-disciplinary team. At worst the use of the word "treatment" has played a not insignificant role in fostering the popular belief that all that is required is to collect and administer a particular drug, to ensure the patient has a supply, and to renew the supply at stated intervals, or even on patient demand.

2.5.2 The objective of remedial attention should be to enable the drug misuser to get back into useful self-supporting employment, and to free him as far as possible from dependence. It follows that the requirements will alter considerably from the time of initial assessment (possibly with short-term hospitalisation), to the period of post-assessment follow-up, assistance with employment, finding of alternatives to drugs, renewed intense attention during occasional periods of relapse, and a continuing interest until the maximum attainable level of stability is reached. Any lesser standards almost inevitably lead to an early and defeatist slide into what amounts to a doctor supported dependence, substituting one form of narcotic dependency for some other no less dependency inducing narcotic. In this report the committee has introduced the word "management" to cover the whole process of remedial attention from the initial and perhaps predominantly medical phase when the physical symptoms of prolonged misuse are uppermost, to the much later stages when the medical aspects may be minimal and social and other supportive measures are the main requirement.

Psychiatric

2.6.1 The committee has long been aware that the term "psychiatric" conveys very different meanings to very many people. Indeed, for quite a number of those who have made submissions in writing or presented such matters orally, the term "psychiatric" may trigger off strong emotive feelings reminiscent of responses still aroused, or even exploited in some quarters, by the term "asylum" or lunatic." It would seem that much of the deep-seated folk fears that formerly attached themselves to the terms "asylum", "lunatic", and even "mental" have, in some minds, transferred themselves to the term "psychiatric". It is, therefore, both desirable and necessary to define the sense in which the

term "psychiatric" is used in this report. The derivation of "psychiatric" is a simple one from two Greek terms meaning "soul" or as it has gradually come to be used nowadays, as "mind", and "physician". The sense to which it is applied professionally is the whole range of observed behaviour and disorders of mental processes that are properly the field of the psychiatrist or doctor who concerns himself with functions and disorders of the mind. There is undoubtedly in the community some awareness of the thin partitions that divide "madness" from "genius" and the undoubted germ of truth in Dean Swift's words that "madness declares itself by unnecessary deviations from the usual way of the world". It is understandable, therefore, that so many people, particularly those who are insecure or uncertain of themselves, are over-anxious to assert their own personal immunity from what they more readily recognise for what it is in others. Such attitudes are a grave impediment to understanding. Yet it is virtually impossible to avoid the use of the term "psychiatric" in reference to the whole range of symtomatology which gives outward visible expression to inner mental processes and conflicts.

2.6.2 Throughout the second report the term "psychiatric" refers to the broad span of outward manifestation of mental processes, and consequences of inner conflict as between the individual and the world around him as he prefers to see it, which are properly the concern of the psychiatrist. Unfortunately almost every one of us places the partition which divides the broad band of the so-called norm from the narrow bands of the more obviously disturbed insecure and asocial at differing points on the scale.

2.6.3 The fact that some distinguished writers or artists have been "psychiatrically disturbed," in the sense that this word is used in this report, in no way derogates from the artistic or literary values of their work, whether or not misuse of drugs was or was not an element in the psychiatric disturbance. By the same token others involved in the misuse of drugs not so gifted or so inclined to the arts or literary work are no less subject to "psychiatric" disturbance or anomalies which find expression in other ways. The "psychiatric" element is common to both.

Trafficking

2.7.1 Trafficking is a term widely used to cover all the offences set out in section 5 of the Narcotics Act 1965 under the heading "Dealing with Narcotics". The section covers offences relating to import or export from New Zealand of any substance, preparation or mixture named or described in clauses (1) to (5) of the First Schedule to the Act, and the production, manufacture, or distribution of any narcotic, or cultivation of any prohibited plant except as permitted by regulations made under the Act. Section 5 (d) prohibits any person not otherwise permitted by regulations under the Act to sell, give, supply or administer, offer for sale, give, supply or administer, any narcotic to any other person, otherwise dealing in narcotics; or as set out in section 5 (e) to have any narcotic in his possession for any of the purposes set out in paragraph 5 (d).

2.7.2 As commonly used, the term "trafficking" embraces all the offences listed under section 5 and may perhaps emphasise, if anything, the larger scale offences relating to importation from overseas and the supply of the illicit market with drugs for the purposes of dealing,

rather than with drugs for the purpose of an individual misuse. In current parlance the term "trafficking" is used almost to the exclusion of the more polite term "dealing" used in the statute. The terms "peddling" and "pushing" are more often used to cover some of the "detail" rather than wholesale aspects of dealing in narcotics. These terms, moreover, are used somewhat loosely and usually convey a derogatory undertone.

Users

2.8.1 As in the report itself and as, for example, in appendix I this term indicates, as in user witness, that the person referred to is involved in recourse to drugs other than in a manner licitly prescribed or, if the drugs have been licitly prescribed, in a manner contrary to the directions of the prescribing practitioner. The word "user" when qualifying persons, be they witnesses or not, clearly implies that the person concerned was a misuser of drugs in the sense the term "misuse" is discussed in the preceding paragraph 2.3.1.

3. CHANGING TRENDS

3.1 During the period under review—February 1970 to May 1973—there have been a number of changes and trends in the New Zealand drug scene. Some of these trends have been both welcome and encouraging, others have been a source of continuing concern. One thing is abundantly clear. The situation is one of rapid change, not only over the country as a whole but also, at any given time, in a particular part or parts of the country. Reference has already been made in section 1.10 to some discernible changes in attitude as reflected in both written and oral representations, on the part of many of those interested in, or involved in, non-medical usage of drugs since the publication of the committee's first report. This section, however, is more concerned with the patterns of usage and of supplies obtained from illicit sources, or by illicit means from licit sources, and in the waxing and waning of interest of particular groups in particular drugs.

3.2 The philosophies, beliefs, and rationalisations of those who regularly or intermittently involve themselves in, or have become dependent upon, recourse to drugs without proper supporting medical indications or real need for such usage are covered elsewhere. Some general reference to these changing trends, however, is necessary for the better understanding of the committee's concern and interest in the person involved rather than the quantities and nature of the drug misused.

3.3 Overall the situation during the period under review is not unlike that summed up in the lines of de Quincy about opium eating in England in 1822:

"Those eat now who never ate before;
And those who ate before eat now the more."

3.4 It is extremely difficult to measure or define the precise extent of increase or fluctuations in the number of persons involved, and the changing nature of associations and attitudes in the many networks they comprise. The findings of individual observers, however close their association with a particular group or groups within the community, are by and large valid only for the groups concerned at that time. Inferences may be drawn with regard to comparable groups elsewhere but even here such inferences are no more than that. Statistics of persons charged with offences under the narcotics and poisons legislation, though useful in themselves and also indicative of changing trends in availability of drugs used, possessed or dealt in illicitly, also refer only to a particular segment of the drug involved population. They require to be reinforced by returns from various other sources such as hospital admissions with diagnoses of drug dependency or overdosage, returns of monitoring of prescribing patterns by the Department of Health, and information known to various categories of health services personnel, social workers, and others whose professional or related services may bring them into contact with the problem at its grass roots.

3.5 Yet other indications may come from information regarding customs seizures of illicit imports; police seizures of similar material, and records of material obtained from licit sources of supply by burglary, theft, or fraud. There is a further factor in assessing the

situation over a short period in so far as the health statistician's published figures for all hospitals by admission and diagnosis, from their very nature, tend to run from 15 to 18 months behind the most recent quarterly return from police and Customs sources relating to offences. They also run well behind information from district health offices' surveillance of prescriptions. Furthermore, a person found to be a drug dependent after admission to hospital may have been admitted for some other condition regarded as the primary diagnosis, and persons admitted for overdosage, whether accidental, fortuitous, or with suicidal intent, may subsequently be found, after investigation, to have a long history of involvement in non-medical usage of some other drugs.

3.6 To facilitate study of the relevant statistics from health and police sources, the Health Services Research Unit of the Department of Health has redesigned the format in which police figures were given in the first report and some brief explanatory notes have been added.

3.7 It should also be clearly borne in mind that the police figures refer only to persons actually charged, not the number of persons who may have come under the notice of the drug squads during the periods to which these statistics refer. Furthermore, quite a number of those who have come under notice, and against whom charges have not been preferred, may have been persuaded or channelled by police officers, concerned for their well-being, into therapeutic or rehabilitative channels. For others a warning has been sufficient to set them on the road towards surmounting by their own efforts, their dependence on, or preoccupation with drugs. It should not be overlooked that in a not insignificant number of instances timely detection and a court appearance has proved to be a lifesaving measure, and a point of departure from previous habit of drug misuse.

3.8 Where the drug misuse scene is studied in successive quarterly returns of persons charged or in returns of hospital admissions for overdosage, coroners' reports, district office data, or the varying emphases given in the not infrequent coverage of the subject in the news media, the most readily identifiable factor common to all these sources is the continuing change in trends.

3.9 Drugs and the particular mode of their administration that may be very much the "in thing" at one time seem to change almost overnight. Some of these changes no doubt reflect the availability of supply. Others reflect a change of focus of interest.

3.10 Drugs become "in" or "out" or merely standbys in much the same way that fashions in clothing make favourite topics of conversation and debate. Even the question of status has a part in changing trends, and, regardless of the problems of availability, drugs that were once greatly sought after and the "in thing" to use seemingly become outmoded or sink into a minor role of standby when nothing else is available. To some extent this changing pattern reflects the multiple drug misusage which has been characteristic of the New Zealand scene throughout the whole period covered by the work of the committee.

3.11 In 1970, when the committee commenced its work leading to this second report, cannabis and, to a lesser extent, amphetamines occupied pride of place, if not in actual usage, certainly in

the coverage by the news media and as a focal point in debate, though amphetamines never developed the mythologies and counter-mythologies that have bedevilled the marijuana issue.

3.12 Even so as is recorded in section 4.74 to 4.79 there were perceptible changes in the type and quality of argument advanced in advocacy of relaxation of controls for use of cannabis.

3.13 During the same year there was a noticeable falling-off in the number of burglaries of pharmacies, doctors' surgeries, and cars which, no doubt, reflected the greater observance of security requirements to which attention was directed in our first report.

3.14 In 1971–72 there was a brief upsurge in the amounts of heroin and opium coming into the country and following conviction and severe penalty in connection with smuggling of opiates, in the main by seamen, a change of pattern in methods of illicit dealings from overseas emerged.

3.15 Individual operators combined to form small syndicates to send one of their number overseas to organise the acquisition and dispatch of supplies, by various channels, to New Zealand. Several of these individuals and amateur rings were broken by the alertness of police services.

3.16 In 1971–72 the focus of interest shifted to LSD which, by the very nature of the extra smallness of the effective dose lends itself more readily than any other substance to overcoming the vigilance of those responsible for the control of illicit traffic. All of the LSD that came into the country during this period, except for one consignment in 1971, was clearly the product of illicit manufacture and there was, equally clearly, a very large variation in the dose contained in flakes of approximately the same size. There were, likewise, variations in the pharmacological nature of LSD in various consignments.

3.17 1971–72 also saw a very marked upsurge of interest in the synthetic opiates and, in particular, the misapplication of a modality of treatment that had been found useful in suitably controlled conditions where heroin dependence was a major source of concern in the countries in question. New Zealand has no such heroin problems.

3.18 Publicity given to various ways in which methadone had been used or advocated in North America in the management of persons who had been heavily involved in heroin over a period of years and specifically ascertained to have been so dependent, encouraged, and led to a demand by persons whose involvement in heroin, or indeed in any opiates, was at least debatable or of a trivial and passing nature and sometimes may have been non-existent in terms of true dependence.

3.19 Relatively large quantities of methadone were handed out on prescription by a very small minority of medical practitioners who had been persuaded that this was appropriate to the needs of the persons presenting themselves and even simply requesting the prescribing of such drugs. In the circumstances prevailing there were no ready means of checking whether a person was confining his request to a single doctor or using the material in the manner laid down by the prescribing practitioner. It very soon came to the notice of the police that in many instances drugs so obtained were used for

intravenous injection or for "trading", sometimes for other drugs, sometimes for cash. Reference to deaths from such methadone availability is made in appendix XI.

3.20 Likewise, monitoring in district pricing offices began to show that the extent of this practice was somewhat more widespread than at first supposed. Inquiries by district health offices show that prescribing of methadone and another synthetic opiate, palfium, was confined to a very small group of practitioners. In the course of discussion with several of these, there was all too little evidence of prior assessment and subsequent follow-up of the person seeking such medication. It also revealed that, amongst those who sought to obtain or use these drugs, palfium was not held in very high regard, particularly if other opiates were obtainable.

3.21 Experience shows in those countries where there was a real heroin problem and where methadone as a modality of treatment had some grounds for acceptance, that abuses very rapidly set in, especially where offering of methadone medication occurred within the restricted limitations of private practice. Canada, in mid 1972, and the United States both found it necessary to lay down stringent criteria for the admissibility of a methadone programme. Similar requirements have obtained in the State of New South Wales since 1969.

3.22 Nothing in the regulatory procedure introduced in these countries, or proposed in New Zealand, interferes with the right of the general practitioner to prescribe opiates for long-established and well-recognised medical needs such as relief of intractable pain and for a number of other conditions.

3.23 The committee has become aware of the increasing numbers of New Zealanders who have become involved in offences against the law relating to drugs in many countries in Europe, Asia, and North America. As the table recorded in appendix IV shows, the number of persons involved has shown a small but steady increase between 1965 and 1969 and a very rapid escalation between 1970 and the period covered prior to the drafting of this second report.

3.24 That by far the greater number of cases should refer to Australia is no occasion for surprise as it has long been known that there is considerable two-way movement of persons involved between New Zealand and Australia. Each country offers the other country's nationals the prospect, sometimes illusory, of at least a temporary lesser likelihood of recognition and detection and greater ease of access to supply in some preferred localities. Improved patterns of co-operation between law enforcement agencies in the two countries have narrowed the margin of advantage and increased the risks of conviction. Nevertheless, there is some comparability between the legal provisions, and those who find themselves in custodial care have at least the mitigation of sharing a common language.

3.25 The situation in many other countries is, however, very different. The penalties for use or simple possession are many times more severe than those that apply in this country, whilst penalties for trafficking offences are not only correspondingly more severe but are also apt to be eagerly enforced even for first offenders. Furthermore, in many countries the procedures by which detected offences are dealt with by the courts is a somewhat tardy process, in the course of which the

persons so charged may well find themselves held in custody in crowded or uncomfortable penal institutions pending the determination of their cases. The examples cited anonymously in appendix IV are based on information provided by the Ministry of Foreign Affairs and the committee, concerned at the time of its study of these matters, have taken the view that there could be some real advantage to New Zealanders at risk if some non specific warnings could be given in any literature of advice to travellers, such as that issued by air lines and travel agencies. This would simply be an extension in the range of health advice already issued but warning of the consequences of convictions in the majority of countries overseas. This matter is excellently covered in Canadian travel literature.

3.26 The New Zealand citizen so involved should expect to face the full rigours and penalties of the country in which he is convicted, sometimes after lengthy periods in custody awaiting trial. Fines may exceed the total resources of the convicted persons and prison terms be both lengthy and uncomfortable.

Recommendation

That when next reprinted the Department of Health pamphlet *Guidelines to Health for International Travellers* be expanded to include advice on misuse of drugs and the often severe consequences of conviction against drug laws and Customs requirements in many overseas countries.

4. DRUGS AND THE LAW

I. INTRODUCTION

4.1 Where the use and misuse of drugs is concerned, the committee is firmly committed to the view that the law should be regarded not as the first line of defence against harm but rather as the last resort, setting the limits within which other and preferably positive sanctions should be brought into play. (Sanctions may be briefly defined as the rewards and punishments which a society or group attaches to approve ways of behaving in order to encourage adherence and discourage their breach.) In the long run, the only truly effective defence against drug misuse lies in the achievement of well-informed and balanced attitudes on the part of the people as a whole to the use of all drugs, including tobacco and alcohol. As the committee wrote in the first report: "The committee's recommendations for action in the fields of control, treatment and research are . . . based upon the belief that these measures will not eliminate and may not substantially reduce the present incidence of drug dependency and drug abuse, unless they are accompanied on the one hand by appropriate action to alleviate as far as possible the conditions which lead some people to misuse drugs, and on the other by a well planned and active programme of drug education".

4.2 We think it significant that some religious or ethnic groups have fared much better than others in restricting the abuse of the most important of all psychoactive drugs, namely alcohol. For instance, heavy drinking is said to be uncommon amongst practising Jews. For them immoderate drinking is a desecration of one of the good things in life, and additional social pressure against it is created by abhorrence of loss of self-control. Gross alcoholism seems infrequent in many Philippine communities as it does also in some other Christian and many Islamic and Bhuddist communities who, however, misuse other psychoactive drugs. If we New Zealanders are to make much progress towards sensible and moderate use of alcohol we shall have to change the widespread and implicit acceptance of the view that heavy drinking and ability to hold one's liquor are signs of manliness and sociability. If we are to limit the misuse of drugs in general to manageable proportions we must modify our present over-tolerant attitudes to the use of chemical substances, including alcohol and tobacco, as a means of dealing with stress and discomfort and achieving pleasurable states.

4.3 The spectrum of substances which are drugs is extremely wide—far wider than is commonly recognised. In this connection the committee draws attention again to appendix VII in its first report. Whether or to what extent particular drugs are controlled by law varies with the extent to which they are considered to be potentially, or actually harmful.

4.4 Laws directed at controlling drugs with potential for harm have two distinct facets. First, there are the provisions for controlling their production, distribution and consumption, and secondly there

are the provisions for penalising those who contravene these controls. Control of production and distribution may involve prohibition, but this is rare; more often it takes the form of restriction to authorised persons for specified purposes, mainly to doctors for prescribing and/or to research workers for particular projects. In New Zealand even heroin is not totally prohibited but is subject to stringent restriction. It is not available through legitimate sources, however, because the countries which produce it legitimately refuse to export it to New Zealand and other states. Contravention of controls involves on the one hand, illegal production (including cultivation in appropriate cases) and distribution, activities referred to in the Narcotics Act 1965 as "dealing", often called "trafficking", and on the other, possession and use of controlled drugs without legal warrant. Public discussion tends to focus attention on the offences of dealing, possession, and use. It is, however, important to remember, first, that the drug legislation provides for other offences such as misleading labelling, failure to maintain the required security, and forgery of prescriptions and secondly, that the existence of all these offences depends upon the legislative decision to control certain drugs in the first place.

4.5 Most people accept without question the need for control of the production and distribution of potentially harmful drugs and the prosecution of those who cultivate, manufacture, and distribute them illegally. There is general agreement over which drugs should be controlled and to what extent, with the major exception of cannabis. Difficulties and controversy arise mainly in connection with the application of legal sanctions to the illegal possession and use of controlled drugs for non-medical purposes. The issue is complicated on the one hand by the fact that there is no victim to lay a complaint or produce evidence, so that the police must take the initiative in locating offences, and on the other because the activities thus identified as illegal frequently present socio-medical problems which require medical treatment and broadly based counselling.

4.6 In the first report we refrained from recommending any changes in the legislation on the grounds that we had not had time thoroughly to examine all the issues involved and that in the case of cannabis the evidence was at that stage far from adequate. Since then we have made this one of our major areas of study, reading widely in the field of legal philosophy, seeking the advice of New Zealand experts on this topic, paying particular attention to the reports of several overseas commissions which have been published in the last year, and initiating a study of sentencing patterns in New Zealand.

4.7 This section is divided into five parts. In the first we outline (rather more fully than in the first report) the present New Zealand legislation dealing with drugs and compare its penalties for the offences of dealing, possession, and use of controlled drugs with those of other countries; in the second, we summarise the results of the study of New Zealand sentencing patterns; in the third, we review the existing legislation with a view to the recommendation of changes; in the fourth we report on international action in the field of drug control since publication of the first report and its relevance to New Zealand; and in the fifth present a summary of our recommendations.

II. DRUG LEGISLATION IN NEW ZEALAND AND OVERSEAS

4.8 The pharmaceutical industry's progressive and rapid development of new drugs has resulted in many of the older preparations becoming redundant and many of the newer drugs being replaced by more recent discoveries. Until fairly recently there was no co-ordinated international effort to gather information regarding adverse reactions which had occurred in different countries from time to time. In consequence the potential dangers of some drugs remained undetected for many years. Furthermore, the drug legislation of many countries, including New Zealand, has developed in a haphazard manner with a number of apparently unrelated and overlapping statutes and regulations. To overcome this lack of co-operation the World Health Organisation has established the Research Centre for International Monitoring of Adverse Reactions to Drugs which is based in Geneva. This centre co-ordinates worldwide reports of adverse drug reactions and supplies member nations, such as New Zealand, with accurate up-to-date information concerning any inherent dangers that have been reported. Such information has led to more uniform controls being applied to drugs in many countries, even though the form of the legislation may be different.

The New Zealand Legislation

4.9 In New Zealand measures for the control of drugs are embodied mainly in the Food and Drug Act 1969, the Poisons Act 1960, and the Narcotics Act 1965, with their respective regulations. The Food and Drug Act sets standards of potency and purity for drugs, or requires manufacturers to set standards of their own which are acceptable under independent review, and places some restrictions on who may distribute drugs. The other two Acts place further limitations and conditions on distribution, possession, and use, especially with regard to the drugs most liable to misuse. (For fuller details see "A Short History of Drugs of Abuse and Drug Abuse Control in New Zealand", in our first report, appendix VIII.)

4.10 The basic legislation is the Food and Drug Act with its regulations. Initially this was concerned with the quality of only a limited range of standard drugs and their labelling, but it has been progressively extended to include proprietary medicines and drugs for which there were no official standards, and to require more informative labelling. The 1969 Act, which became effective on 1 April 1970, includes new sections which require:

(a) New drugs to have the consent of the Minister and notification in the *Gazette* before distribution in New Zealand.

(b) Existing drugs for which changes in formulation, packaging, or indications have been made to be notified to the Department of Health before distribution of the changed form or indications takes place.

All information concerning new or changed drugs is evaluated for accuracy of identification, formulation, and quality control procedure; and also for effectiveness, safety, and hazards (if any). The legislation now specifies the names of those drugs which may be sold by persons lacking formal training about drugs and their effects.

4.11 The Poisons Act 1960, which in its original form antedated the food and drug legislation, has also been expanded from time to time along with its regulations. This Act deals not only with drugs but also with commercial and general products which can cause harm to individuals or to the community. The drugs controlled by the Act are of virtually every type of action, including stimulants, depressants, hallucinogens, antibiotics, hormones, and some which pharmacologically resemble narcotic action, such as pentazocine. Initially concerned only with the licensing of vendors and elementary labelling, it has been amplified by the addition of requirements regarding packaging, more informative and warning labelling, the keeping of sales records, more particularity in licensing and conditions of production and sale (including restriction of many substances to "prescription only" supply), and the control of supply to persons dependent on drugs which are poisons. It makes the illicit production and sale of poisons an offence, and also the possession of "prescription only" drugs without proper warrant, which warrant must be advanced by the possessor as a defence. Licit possession of a "prescription poison" is limited to persons authorised or licensed under the Act or regulations. These persons are:

(a) A pharmacist;
(b) A veterinary surgeon;
(c) A medical practitioner;
(d) A dentist;
(e) A wholesaler who is licensed;
(f) A person obtaining that prescription poison by purchase for extended purposes;
(g) The master of a ship;
(h) A person in charge of an aircraft;
(i) An officer under the Food and Drug Act;
(j) An analyst under the Food and Drug Act or an approved person in charge of a laboratory;
(k) Duly authorised staff in hospitals;
(l) A patient under the care of a medical practitioner or dentist;
(m) Any person for the treatment of an animal under the care of a veterinarian;
(n) A person caring for a patient under the care of a medical practitioner or dentist;
(o) A person in charge of an approved first aid kit.

Section 26 of the Act also approves a carrier when carrying a prescription poison in the course of his duties. Under this Act offences of dealing and of possession and use all carry a maximum penalty of 3 months' imprisonment and/or a fine of $400.

4.12 The Narcotics Act 1965 (and its predecessor the Dangerous Drugs Act 1927) differs from the Poisons Act in that regulations 37–47 of the regulations made under that Act (Narcotics Regulations 1966) require quantitative accounting control of the drugs to which it applies, draws more tightly the conditions for authorising vendors, suppliers, and those in possession, and adds restrictions on use. The substances controlled are named in the Act itself in the First Schedule comprising six parts. Most are pharmacologically narcotic drugs, but some psychomotor stimulants (for instance cocaine) and hallucinogens (for instance LSD, mescaline, and cannabis) are included. For the purposes of the

Act these are all defined legally as "narcotics". The maximum penalty for illicit production and distribution of any of the drugs named is 14 years' imprisonment or on summary conviction a fine of $2,000 and/or a maximum term of 3 years' imprisonment, which is much higher than under the Poisons Act. The offences of possession and use have a maximum penalty of 3 months' imprisonment and/or a fine of $400.

4.13 Two points should be carefully noted. First, the penalties named in the various laws relating to the control of drugs are maximum penalties not mandatory ones. There are no minimum penalties as there are in some countries. In sentencing offenders after conviction, magistrates and judges have a choice, within the limits of the maximum for a particular kind of offence, of a range of penalties which can be imposed for varying periods and in varying combinations, namely: discharge with or without costs, fines of varying magnitudes, probation, and several different forms of detention—periodic detention, detention centre, borstal training, and prison. They may make discharge conditional on voluntary admission to hospital or associate it with referring an offender to hospital under the Alcoholism and Drug Addiction Act 1966. Secondly under section 39 (b) of the Criminal Justice Act 1954, a charged person can be held in interim custody and required to have medical and other evaluation and treatment before he comes to court, only when the offence concerned carries a penalty of imprisonment or death.

New Zealand Legislation Compared with Overseas

4.14 The New Zealand law, in respect of drugs obtainable only on prescription, requires medical practitioners in their prescribing and pharmacists and others in their dispensing, supplying, and administering, to state in writing on prescriptions and labels and in records (where records are required to be kept), the description and quantity of the drug, the dates of supply and directions as to quantity, frequency, and method of use. Greater detail is required than in most other countries.

4.15 The New Zealand law also requires to a greater extent than in most countries that persons legally in possession of drugs capable of misuse keep, and where required produce, information or records which demonstrate that they are acting accountably in this regard.

4.16 The New Zealand law draws a distinction, more clearly than in many other countries, between the legitimate patient and the illicit drug user. This is not merely a question of whether a person received the drug on a doctor's prescription, on the one hand, or from an illicit source on the other. In New Zealand, if a patient fails to disclose he is receiving medication (such as, for example, narcotic or psychoactive drugs) from one doctor when he approaches another for such medication, or if he uses a prescribed drug in a manner departing from the prescribed instructions (as, for example, taking by injection a drug intended for oral use) his possession or use of the drug concerned becomes illicit. A responsibility is placed on the user as well as on the prescribing doctor. Failure to exercise such responsibility may amount to an offence under one of several Acts and thus exposure to prosecution.

4.17 With respect to the supply of narcotic drugs to patients who are or are deemed likely to become dependent on such drugs, New Zealand exercises less control than has been accepted for some years overseas, especially in the United Kingdom, United States, and Canada. Prior to the recently amended section 25 of the Narcotics Act 1965, there was no restriction of the right of doctors in general to prescribe narcotics to patients for any reason whatever. However, under the Narcotics Regulations 1966 medical officers of health are empowered to act to modify prescribing or supply procedures from those laid down in regulations or to limit legitimate sources and quantities of supply, with respect to specific drugs or specific practitioners. They may also arrange for a particular drug-dependent patient to uplift daily supplies of a prescribed narcotic from a specified pharmacy, in order to reduce the frequency of his visits to his doctor or to limit the quantity of the drug in his possession at any one time.

4.18 Maximum penalties for illicit production, manufacture, distribution, and sale of drugs, offences commonly subsumed under "dealing", vary widely from country to country, ranging from 3 years to life imprisonment and, in a few cases, the death penalty. The New Zealand maximum penalty for offences of this sort falls roughly in the middle of this range, approximating as it were the average level. (For details of the penalties for offences involving cannabis in a range of Single Convention countries see appendix VI.)

4.19 On the other hand, the New Zealand maximum penalty for the illicit possession and use of controlled drugs is amongst the *lowest* in the world, being one-quarter or less of those of most countries. Moreover, New Zealand is one of the few which does not prescribe a minimum penalty on conviction but leaves to the courts the "benign exercise of discretion". The recommendations of the Wootton report regarding penalties for possession and use of cannabis have been represented to the committee as a suitable model for the amendment of New Zealand penalties. In fact, however, the maximum penalty suggested in the Wootton report (4 months' imprisonment) is *higher* than the present New Zealand maximum of 3 months.

Reports from Overseas Commissions

4.20 Currently with the inquiries of this committee, somewhat similar examinations into drug misuse have been, and are being, made by commissions in Australia, Canada, the United Kingdom, and the United States. The committee has had some personal contact with members of these commissions and examined their reports with great interest. (See appendix III.) Their findings and recommendations have obvious relevance to the task we are engaged upon in this report. However, we should like to point out that fully to understand and appreciate their findings, and especially their recommendations, it is necessary to take account of differences in history, economy, social structure, social services, constitution, law, and administrative and legal processes. It must also be recognised that many of the terms which are used in discussion of the control and misuse of drugs, and embodied in legislation, have subtly or even markedly different meanings from country to country. On these grounds alone it would be most inadvisable to attempt to apply the literal wording of overseas recommendations to the New Zealand situation.

III. DRUG OFFENCES IN NEW ZEALAND—A STUDY OF SENTENCING PATTERNS

4.21 Before considering any changes in the laws controlling drugs or in the penalties for offences against such laws, the committee felt it was important to find out more about the application of the existing laws. In 1971, at the request of the committee, which has no research funds of its own, the Department of Health commissioned a research worker, Miss Margaret Geddes, to make a study of the sentences imposed in cases involving drug offences in five main centres for the 2 years 1969 and 1971. This study was carried out with the co-operation of the Police and Justice Departments, who gave the research worker access to court and departmental records, and with a commitment of confidentiality regarding information on the files examined. The results of this study are presented in tables and commentary in appendix VII. In this section, we will concentrate on the aspects of this inquiry we consider most relevant to our purposes.

4.22 In the first place this study clearly established that, in sentencing those convicted with offences against New Zealand drug laws, magistrates and judges have very rarely imposed or even approached the maximum penalties for the offences concerned detailed in paragraphs 12 and 13. Indeed, in the case of offences of trafficking, cultivation, and illicit importation maximum penalties *have not, as yet, ever* been imposed. (See appendix VII, table 5.) Taking the 2 years under review, in 1969 out of a total of 102 convictions for drug offences the highest term of imprisonment given for a dealing offence was 3 years and the highest fine $350. For the possession or use of a controlled drug only one offender received the maximum of 3 months' imprisonment and the highest fine imposed was $250. In 1971 out of 333 convictions, the highest term of imprisonment imposed for a dealing offence was 7 years and the highest fine was $800, while for the offences of possession or use only five persons received a sentence of 3 months' imprisonment and the highest fine was $300.

4.23 Secondly, while the magistrates and judges imposing sentence made use of all the types of penalties available to them, the preponderance of sentences given fell very much towards the lower end of the range. A simple breakdown of sentences given in each year for offences of all kinds (tables 3 (a) and (b)) shows that a very small percentage involved detention in penal institutions. Only 8 percent were sentenced to periodic detention, detention centres, or borstal training in 1969 and 9 percent in 1971, 8 percent to prison in 1969, and 12 percent in 1971. A much higher percentage of sentences involved probation with or without fines (25 percent in 1969 and 27 percent in 1971). Fines only accounted for over one-third (36 percent in 1969 and 35 percent in 1971), and approximately one-tenth (12 percent in 1969 and 10 percent in 1971), were convicted and discharged without penalty. A relatively small and decreasing percentage was sent to hospital: 8 percent in 1969 and 5 percent in 1971.

4.24 When the offences of dealing are distinguished from those of possession or use, marked differences emerge in their respective sentencing patterns (table 5). Those convicted of dealing offences

received a much higher proportion of sentences involving detention in penal institutions (32 percent in 1969 and 49 percent in 1971) than those convicted of possession or use (12 percent in both years) and lower proportions of sentences involving probation with or without fines (22 percent in 1969 and 19 percent in 1971, compared with 26 percent and 29 percent). Fines only (27 percent in 1969 and 19 percent in 1971, compared with 40 percent and 29 percent), and discharges (5 percent in both years compared with 14 percent and 11 percent). Within the broad category of sentences involving detention, those convicted of dealing offences received prison more often than other forms of detention, the ratio being 6:1 in 1969 and 27:7 in 1971, while those convicted of the offences of possession or use received prison sentences less often than other forms of detention, the ratio being 2:7 in 1969 and 8:23 in 1971. (The figures for "other offences" are too small for meaningful analysis.)

4.25 Thirdly, when the sentences given in the 2 years are analysed on the basis of the factors of sex, age, drug involved, previous record for drug and non-drug offences, associated offences, and the use of background reports, the differences in pattern which emerge demonstrate that, as was to be expected, magistrates and judges do take these factors into account.

4.26 In 1969 no females were sentenced to prison or any other form of detention; in 1971 the proportion of convicted females who were sentenced to prison was just half that of the males, while barely 1 percent of the females were sentenced to other forms of detention compared to 11 percent of the males. (Tables 4 (a) and (b).) (In New Zealand women and girls cannot be sentenced to either periodic detention or detention centres, only to borstal training.) The difference may be at least partly explained, of course, by differences in the patterns of offending by males and females as well as in the sentencing patterns.

4.27 Analysis of sentences by age groups (tables 4 (a) and (b)) reveals that those under 20 received approximately the average proportion of sentences involving fines only or probation with or without fines (compare with paragraph 22 above), but a higher proportion of discharges (12 percent in 1969 and 15 percent in 1971), a higher proportion of lesser detention sentences (19 percent in 1969 and 14 percent in 1971), and a very low proportion of prison sentences: only one was sentenced to prison in 1969 and none in 1971. In comparison those in the 20-24 years age group received proportionately fewer discharges (11 percent in 1969 and 8 percent in 1971), fewer minor detention sentences (2 percent and 9 percent), and more prison sentences (11 percent and 16 percent).

4.28 Before looking at the relationship between sentences and type of drug, it is important to point out that in both 1969 and 1971, cannabis was by far the most common drug to figure in convictions. (Tables 6 (a) and (b).) Even when the cases in which it was named in association with other drugs are excluded, its incidence increased from 33 percent in 1969 to 46 percent in 1971. In 1969 the opiates (opium, heroin, morphine salts, methadone, and pethidine) ranked next with 24 percent, followed by the central stimulants including cocaine (14 percent) and barbiturates and hypnotics (8 percent),

with no cases of LSD at all. In 1971, though the opiates retained second place, they did so through a large and probably temporary increase in the number of cases involving opium, and their overall proportion dropped to 16 percent. LSD had jumped into third place with 12 percent, the percentage of cases involving central stimulants had dropped to 7.5 percent, and barbiturates to 2.7 percent, the latter now being more than matched by illicit use of tranquillisers (3 percent). As we observed in the first report (5.22), the pattern of illegal drug use varies markedly over time and is closely related to availability of the drugs concerned.

4.29 One of the most important questions for our purposes is the extent of correlation between sentences, type of offences, and type of drug. When offences of possession and use are separated from dealing offences, it becomes clearly apparent that the type of drug involved has a major influence on the sentencing pattern. (Tables 7 (a), (b), (c), and (d).) Of those convicted of the possession or the use of cannabis, a lower proportion than average was discharged (8 percent in 1969 and 5 percent in 1971), but an exceptionally high proportion received lesser penalties of fines and/or probation (81 percent in 1969 and 83 percent in 1971). In 1969 out of a total of 27 convicted for these offences, none was sentenced to periodic detention, detention centre, or borstal training and only two to prison; in 1971 when the number convicted had risen to 112, only 7 were given lesser detention sentences and 4 were sent to prison, barely 10 percent altogether. Only one person convicted on a cannabis charge was sent to hospital, in 1969.

4.30 In comparison those convicted of the possession or use of opiates, in all a much smaller total, received a higher than average proportion of sentences to periodic detention, detention centre, or borstal training (20 percent in 1969 and 21 percent in 1971), and a higher proportion of hospital referrals (10 percent in 1969 and 19 percent in 1971), though only one was sentenced to prison in 1971. Possession and use of central stimulants, barbiturates, hypnotics, and tranquillisers (drugs covered, except for cocaine, by the Poisons Act) attracted non-detention sentences almost entirely, only three such offenders being sentenced to detention and none to prison. The pattern of sentencing for possession or use of LSD in 1971 was very close to that for cannabis. Having regard to relative dosages and potency this is clearly an anomaly.

4.31 While the numbers involved in dealing offences, when broken down by type of drug, are really too small to be statistically significant they would seem to suggest that the courts do take account of the differences in the type of drug. Those dealing in opiates received more severe penalties than those dealing in cannabis. In 1969 four out of six and in 1971 five out of six of those convicted for dealing in opiates received prison sentences, though none for more than 3 years. In comparison, less than one-third of those convicted of dealing in cannabis were sent to prison: 2 out of 7 in 1969 and 11 out of 39 in 1971. On the other hand, those convicted of dealing in LSD received more severe sentences than those dealing in cannabis, 7 out of 12 being sent to prison in 1971, 3 of them for 3 years. The quantities, however, measured in terms of doses, were significantly high in each of these cases.

4.32 The large majority of those convicted of drug offences are first offenders as far as drugs are concerned, 67 percent in 1969 and 75 percent in 1971, and the numbers of those with previous drug convictions are thus comparatively small. (Tables 8 (a) and (b).) As might be expected a previous record of one or more drug offences did have some effect on sentences. In 1969 the 19 with such a record received sentences of fines and/or probation less often than first offenders (47 percent compared with 64 percent), but they also received detention sentences less often, only 2 being sent to prison and none to other detention institutions, while 4 were sent to hospital (20 percent compared with 5 percent of the first offenders). In 1971, however, when the numbers were higher, the pattern showed a marked change: those with a previous record of drug offences received a much higher proportion of detention sentences, 18 percent receiving the lesser forms and 30 percent being sent to prison, compared with 8 percent and 10 percent respectively of the first offenders, and the proportion sent to hospital (14 percent) was lower than in 1969, though still much higher than for first offenders (2 percent). To put it another way, whereas those with previous convictions for drug offences made up only 25 percent of the total number convicted in 1971, they accounted for 37 percent of those sentenced to prison.

4.33 In both 1969 and 1971 approximately 3 in 10 of those convicted of drug offences were also convicted of associated offences at the same time. (Tables 9 (a) and (b).) In both years those convicted of other than minor associated offences (that is of offences listed in columns 4 to 10 of tables 9 (a) and (b)) received a higher proportion than average of detention sentences on the one hand and of hospital referrals on the other. For instance, of the 95 involved in 1971, 11 were sentenced to lesser forms of detention and 17 to prison, while 11 were referred to hospital.

4.34 A similar pattern appears again in the case of those with previous convictions for non-drug offences. (Tables 10 (a) and (b).) In both 1969 and 1971 26 percent of those convicted of drug offences had previous convictions for other than minor non-drug offences, that is for offences listed in columns 4 to 10 in tables 10 (a) and (b). Of the 29 involved in 1969, 4 were sentenced to periodic detention, detention centre, or borstal training, 3 to prison, and 7 were referred to hospital. The corresponding figures for 1971 were 10, 16, and 5 out of 85, an increase in the proportion sent to prison and a decrease in the proportion sent to hospital.

4.35 The bench requested reports from probation officers, welfare officers, or psychiatrists in a majority of the cases tried in both years, the proportion rising from 58 percent in 1969 to 82 percent in 1971. The sentences imposed on those convicted were in line with the recommendations made in 86 percent of the reports received in 1969 and 80 percent in 1971. Some differences were apparent in the frequency with which reports were requested and followed for different types of offences and different types of drugs. Reports were requested rather more often in respect of charges of dealing or of theft or forgery (in 81 percent of the cases in each category in 1971) than they were for charges of possession or use (69 percent in 1971). In sentencing, the bench followed the recommendations in a notably high proportion

of the reports relating to charges of possession and use (90 percent in 1971) but in a rather lower proportion of those relating to dealing (79 percent) or theft or forgery (75 percent). Reports were requested in a high proportion of cases involving cannabis resin (91 percent in 1971), morphine or heroin (86 percent), or opium (83 percent), in a rather lower proportion of cases involving cannabis plant (71 percent) or barbiturates, hypnotics, or tranquillisers (67 percent), and relatively infrequently in cases involving central stimulants (39 percent). Recommendations made in reports were followed in sentencing most often where the drugs concerned were barbiturates, hypnotics, and tranquillisers (86 percent) and least often where they were morphine or heroin (56 percent).

4.36 The number sent to hospital decreased as a proportion of total convictions from 8 percent in 1969 to 5 percent in 1971. Further inquiry would be needed to establish whether this was because the judiciary made less use of this alternative and, if so, why; or because proportionately fewer of those convicted needed hospitalisation. An increase in cannabis offences may account in part for the difference. The proportion of the hospital referrals in which the Alcoholism and Drug Addicition Act was used increased between 1969 and 1971, but was still very low for drug offenders.

4.37 In the years under study New Zealand magistrates and judges made only limited use of the maximum penalties attached to drug offences, especially imprisonment. For some offences the maximum was never awarded. Magistrates and judges imposed sentences from the range available showing that they took into account a great variety of factors, notably the sex, age, and previous record of the offender, the type of drug involved, associated offences, and probation and other reports. In particular it would seem that an offence of possession or use was unlikely to attract a sentence of detention or a heavy fine if the drug involved was cannabis and if the offender was under 20 and appearing in court for the first time or on other than a minor charge, unless there were exceptional circumstances such as association with a more serious offence, for example, dealing, burglary, or fraud.

IV. REVIEW OF THE EXISTING NEW ZEALAND LEGISLATION

Controls on the Availability of Drugs

4.38.1 It is generally accepted without question that the State has a responsibility to place controls on the availability of drugs with potential for harm. The discovery of new and potent therapeutic drugs particularly over the last three decades has brought with it enormous potential for good when these agents are properly used but, by virtue of their potency, perhaps as great a potential for harm if improperly used, or if distributed for use before they have been adequately tested for safety.

4.38.2 The thalidomide tragedy made this all too obvious and in countries throughout the world controls were subsequently tightened. New Zealand enacted the Food and Drug Act 1969 which came into force on 1 April 1970. This legislation defines a therapeutic drug

and requires any person wishing to distribute a new therapeutic drug to obtain the consent of the Minister of Health. It is an offence to sell or distribute in any way a new therapeutic drug, or to advertise its availability, before the consent of the Minister has been notified in the *Gazette*. The gravity with which an offence of this nature is viewed is reflected in the penalty provided: imprisonment for a term not exceeding 6 months or a fine not exceeding $5,000 or both.

4.38.3 Persons wishing to distribute a new drug may apply for the consent of the Minister through the Director-General of Health. Acting under the powers conferred by section 13 of the Food and Drug Act 1969 the Department of Health requires full details concerning the drug including the chemistry, toxicity, pharmacology, clinical trials of the drug, known side effects, and adverse drug reactions as well as reports of the manufacturing methods and quality control of both the active and other ingredients, and of the final product. In the case of a completely new drug this information must cover fully the investigations carried out during its development such as animal studies prior to its use in humans, to establish as far as possible its effect, safety, and possible teratogenicity, and the initial trials in humans following the work done with animals. Claims that a drug has been approved for distribution in a country other than New Zealand must be substantiated. The committee draws attention, however, to what pharmacists sometimes call the "grandfather effect". There are still available a great many drugs, probably the majority, which were introduced before the "new drug" provisions and for which the information currently required for a "new drug" has not as yet been officially sought, assembled, and evaluated. Assessment of their safety is based on long experience in use.

4.38.4 All applications are processed by the Clinical Services Division of the Department of Health. Drugs which are well known but are new by virtue of a new manufacturer, and drugs which have been accepted by the Food and Drug Administration of the United States, the Committee on Safety of Drugs in the United Kingdom, or by the Australian Department of Health are in general accepted subject to satisfactory quality control. If there is any doubt they are referred to the Drug Assessment Advisory Committee, an expert technical committee set up by the Minister to advise him, under section 20 of the Food and Drug Act 1969. This committee also considers applications for all new drugs which do not fall into the above categories and advises the Minister of their suitability or otherwise for distribution in this country. The Drug Assessment Advisory Committee is composed of two persons nominated by the Medical Association of New Zealand (currently a professor of pharmacology and a lecturer in clinical pharmacology), two nominated by the Pharmaceutical Society of New Zealand (currently a professor of pathology and a tutor in pharmacology), three nominated by the Department of Health (currently a professor of medicine, a lecturer in medicine, and the deputy director of the Division of Clinical Services), and one other person, nominated by the Minister of Health (currently a chemist).

4.38.5 In addition to the prime function of the committee to consider new drugs it also advises on any other matters relating to

the distribution of drugs, including applications to sell proprietary drugs from outlets, other than pharmacies, such as chain stores, supermarkets, or country stores.

4.38.6 There is also a subcommittee to which urgent matters concerning reported adverse reactions to drugs can be referred between regular meetings of the full committee.

4.38.7 Once a drug has been gazetted as having been approved by the Minister for distribution it must comply with the relevant requirements of the Food and Drug Act 1969, the Poisons Act 1960, and the Narcotics Act 1965 which, collectively, control the labelling, storage, and availability of the drug concerned.

4.38.8 Broadly, drugs may be divided into three groups: those which may be sold generally, those which may be sold only by a pharmacist, and those which may be supplied only by a doctor or a pharmacist on a doctor's prescription. Before any drug is restricted to availability on a medical, dental, or veterinary practitioner's prescription the matter is referred to the Poisons Committee set up under section 6 of the Poisons Act 1960 to consult with the Minister of Health. This committee is composed of two persons nominated by the Medical Association of New Zealand, two persons nominated by the Pharmaceutical Society of New Zealand, and three persons being officers of the Department of Health.

4.38.9 It is clear that the control of new drugs coming on to the market in New Zealand and the restrictions, if any, on their subsequent distribution should receive close attention in order to ensure, as far as practicable, good quality, safe usage, and efficacy.

4.39 Criticism of existing legislative controls has been centred mainly on cannabis, which is virtually prohibited (being available only for research purposes under strict conditions), and amphetamines, all forms of which until recently, were available on prescription by any doctor.

4.40 In New Zealand, as in most western countries, there has in recent years been considerable publicity for advocacy of a relaxation of the existing controls on cannabis, with many expressing themselves in favour of "legalisation". By this some mean merely the lifting of penalties against possession and use, but the more thoughtful realise that "legalisation" would require the State to plan and implement extensive controls on legal production and distribution, along the lines of those that apply to alcohol and tobacco. Not even the most ardent of the cannabis users who have made representations to this committee approve of its unrestricted availability, for instance to children of school age. The committee discusses this issue in full in sections 7.22 to 7.26 and gives there its reasons for supporting continuation of restrictions on cannabis.

4.41.1 In the case of amphetamines, pressure has been exerted in the opposite direction, in favour of tighter controls. Since the middle sixties there has been a growing conviction in the medical profession that the therapeutic value of amphetamines is extremely limited, and that a considerable potential for misuse exists. This view was expressed in our first report. Other countries have taken steps to control their use and distribution. In the United Kingdom the medical profession advocated a voluntary ban on their use in 1970 and legislative control

was provided for in the Misuse of Drugs Act 1971. New South Wales law requires the permission of the Director-General of Public Health before they may be prescribed in the treatment of a drug addict, or for periods in excess of 2 months to other persons. Canada restricted use of amphetamines and phenmetrazine and phendimetrazine as from 1 January 1973 to the treatment of narcolepsy, hyperkinesis in children, and such other conditions as may be recommended.

4.41.2 In 1972 New Zealand amended the Poisons Regulations to restrict the availability and supply of amphetamines to those forms of the drug which are available under the Drug Tariff 1970, namely, amphetamine sulphate, dexamphetamine sulphate, and methylamphetamine hydrochloride. These may be obtained only on the prescription of a medical practitioner and only from hospital pharmacies. The sale of all other amphetamine preparations is prohibited entirely. Thus a middle course has been steered involving more control than a voluntary ban but less stringent conditions than the Canadian proposals.

4.42 The New Zealand legislation controlling drugs and poisons is now so complex and scattered that even pharmacists have difficulty sorting out the relevant regulation when trying to discover what restrictions, if any, apply to a particular compound. The committee agrees with the Department of Health that the time has come to consolidate the provisions for control of drugs with a significant potential for misuse in a single Act. More detailed recommendations along these lines are given in the final part of this section.

Legal Sanctions Against the Illegal Production and Distribution of Drugs

4.43 As indicated in part II above, the maximum penalties which New Zealand courts may impose for the illegal production and distribution of controlled drugs (that is, for dealing) are in line with the general trend of maximum penalties overseas, except that they do not include life imprisonment or the death penalty. The study of sentencing patterns in part III of this section suggests that the judiciary generally takes the type of drug into account when imposing sentence for dealing offences as well as for those of possession and use. The committee recommends that, in the formulation of the new legislation it has suggested, the present maximum penalties for dealing be retained but that some differentiation of maxima be introduced related to significant differences in the potential for harm of different drugs.

4.44 The committee also recommends that there be a restricted definition of the word "supply" which is not defined in the present Narcotics Act. A revision of the quantities named is also recommended. In the absence of a statutory definition the word "supply" does not enable the court to distinguish clearly in the matters of the methods of consumption of different drugs, in the scale of operations, or in the extent to which the profit motive is involved. Under the present legislation handing a marijuana reefer to another technically constitutes "supplying", yet sharing without profit is a feature of the way in which marijuana is commonly consumed among friends. We are confident from the evidence of the sentencing study that magistrates do in fact take such differences into account, but we regard the proposed revision of the legislation as a good opportunity for clarifying the matter.

4.45 At present section 5 (6) of the Narcotics Act specifies the quantities that possession of which founds the presumption that possession is for the purpose of dealing. In view of the increase in the range of drugs involved, changes in patterns of illegal distribution and consumption, and increasing pharmacological knowledge the quantities specified are no longer appropriate. There are vast differences in the number of doses to be found in a given quantity of different drugs. Cannabis for instance is positively bulky compared to heroin and LSD. The number of doses taken over a given period (say 24 hours) also varies significantly with the drug, and to a lesser extent with the experience of the user. A person who is heavily dependent on heroin or a chronic user of cannabis may seek to and wish or even need to hold much larger quantities for his own use than an occasional user. Moreover, drugs produced illegally and not diverted from legitimate production sources can be quite unpredictable in quality and potency: the effective or dangerous dose can be extremely small, especially in the case of LSD, or larger than with good quality material in the case of cannabis, a circumstance which also has its dangers, since users accustomed to larger doses of poor quality may be unprepared for the potency of high quality material. In revising the legislation, these factors should ideally be taken into account, with sufficient flexibility for speedy inclusion of new substances found to be susceptible of misuse.

Legal Sanctions Against Illegal Possession and Use of Controlled Drugs

4.46 Our present laws penalise the illegal possession and use of controlled drugs in terms of blanket provisions, without specific regard to the type of drug involved, the method and circumstances of administration, or the degree and nature of harm actually caused.

4.47 Many people argue that possession and use of drugs outside medical supervision falls into the area of private morality and should not be subject to the criminal law, because there is no victim other than the user himself. The question must be seen as part of a wider on-going debate on the nature and purposes of the criminal law, and the circumstances if any under which the State is justified in using it to impose limits on the liberty of the individual. This debate is so important and relevant to the subject in hand that the committee proposes to include a summary of the main arguments.

The Use of the Criminal Law

4.48 The classic exposition of one side of the argument is to be found in John Stuart Mill's essary *On Liberty*, in which he asserts "one very simple principle . . . that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. . . . The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute." (*Everyman,* edition, 1973.) Mill emphasises the fundamental value of freedom, not as an abstract principle or independent good, but as an utilitarian value, or

as necessary to the development and well-being of both the individual and society. However, he admitted one very important qualification to his general principle: "It is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children, or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury."

4.49 In 1957, the whole debate was reopened with the publication of the report of the Committee on Homosexual Offences and Prostitution (commonly known as the Wolfenden report) in Britain. In this report, the committee wrote: "There appears to be no unquestioned definition of what constitutes or ought to constitute a crime. To define it as an 'an act which is punished by the State' does not answer the question: What acts ought to be punished by the State? We have therefore worked with our own formulation of the function of the criminal law so far as it concerns the subjects of this enquiry. In this field, its function as we see it is to preserve public order and decency, to protect the citizen from what is offensive or injurious, and to provide sufficient safeguards against exploitation and corruption of others, particularly those who are specially vulnerable because they are young, weak in body or mind, inexperienced, or in a state of special physical, official or economic dependence." (Paragraph 13.)

4.50 "It is not in our view the function of the law to intervene in the private lives of citizens, or to seek to enforce any particular pattern of behaviour, further than is necessary to carry out the purposes we have outlined." (Paragraph 14.)

4.51 With regard to the issue of law and morality, the Wolfenden committee recognised that "the laws of any society must be acceptable to the general moral sense of the community if they are to be respected and enforced", but stressed "the importance which society and the law ought to give to individual freedom of choice and action in matters of private morality. Unless a deliberate attempt is to be made by society, acting through the agency of the law, to equate the sphere of crime with that of sin, there must remain a realm of private morality and immorality which is, in brief and crude terms, not the law's business. To say this is not to condone or encourage private immorality. On the contrary, to emphasise the personal and private nature of moral or immoral conduct is to emphasise the personal and private responsibility of the individual for his own actions, and that is a responsibility which a mature agent can properly be expected to carry for himself without the threat of punishment from the law." (Paragraphs 12 and 61.)

4.52. The Wolfenden formulation was challenged by Sir Patrick (now lord) Devlin, who argued for a much closer connection between criminal law and general morals. Society, he said, is entitled by names of its laws to protect itself from dangers whether from within or without. Since an established morality is as necessary as good government to the welfare of society there can, in theory, be no area of purely private morality from which the State is absolutely barred. At the same time, however, Devlin also asserted that "there must be toleration of the maximum individual freedom that is consistant with

the integrity of society", and that "before a society can put a practice beyond the limits of tolerance there must be a deliberate judgment that the practice is injurious to society." (*The Enforcement of Morals,* 1965: 16 and 17.)

4.53 Taking his stand with Mill against Devlin, Professor Hart, of the University of Oxford, insisted that the freedom of the individual was a value of paramount importance and that any restrictions placed upon it required to be justified for other reasons than morality alone. He was, however, prepared to go further than Mill in making exceptions, and to extend the purposes of the criminal law to cover the protection of individuals from self-inflicted harm as well as harm inflicted by others, that is to countenance a degree of "paternalism": "Certainly a modification in Mill's principles is required . . . But the modified principles would not abandon the objection to the use of the criminal law merely to enforce positive morality. They would only have to provide that harming others is something we may still seek to prevent by use of the criminal law, even when the victims consent to assist in the acts which are harmful to them." (*Law, Liberty and Morality,* 1963: 33.)

4.54 Here in New Zealand the issue has been explored in *Essays on Criminal Law in New Zealand* edited by Roger Clark, in particular in "Limitations of Criminal Law" by C. J. F. Parkin, senior lecturer in philosophy at Victoria University of Wellington. Discussing the problem of defining "injury to society", Parkin points out that there are many acts which affect other individuals adversly without being recognised as crimes, and that those which *are* considered crimes injure relatively few people in proportion to the total society. On what grounds can a difference legitimately be made? Parkin clarifies the issue by making a distinction between the interests of society as a whole and those of particular members of society. The former are closely related to the provision of a reliable social framework in which individuals can operate without being overwhelmed by excessive demands on their physical or mental resources. Actions which create widespread fear, anxiety, uncertainty, or offence among citizens are a threat to the public interests of society, even when they injure few individuals directly, for instance, murder, arson, assault, indecent exposure. As examples of "public interests" Parkin lists: peace and security, law and order, minimum standards of living, the familial structure of society, public health, certain economic institutions, the welfare of the disabled, defective and dependent, and morals. In his view, then, a society may legitimately intervene, through the agency of the criminal law, when a course of behaviour does or would tend to damage the public interests. However, accepting that it may does not mean that it *must*. On the contrary, Parkin sees society as having a responsibility to consider alternatives and to delay resort to the criminal law whenever possible.

4.55 Parkin makes two other most important points. First, public interests are not fixed or absolute: "what precisely the public interest boils down to cannot be precisely stated for all time. It is likely to change, perhaps slightly, perhaps significantly . . . because it is inseparably wedded to 'the general moral sense of the community' and to public opinion." (*Essays on Criminal Law* :41) Secondly, the

public interest is not inimical but closely related to the interests of the individual. "A public interest in morals, of its very nature, commits us to a public interest in the liberty of the individual to be his own moral guide . . . so long as we see an orderly social framework as the means of maximising individual liberty rather than say a tool for promoting the interests of a power group." (ibid.: 42.)

4.56 Though they start from different premises and place their emphasis in different places, most of the protagonists in this debate would agree with the principles adopted by the Le Dain Commission in its interim report, that "society has a right to use the criminal law to protect itself from harm which truly threatens its existence as a politically, socially and economically viable order for sustaining a creative and democratic process of human development and self-realisation", and that "the criminal law should not be used for the enforcement of morality without regard to potential for harm." (Paragraphs 443 and 444.) Even here, however, there is room for difficulties in interpretation, for people's perception of what constitutes a truly "viable social order",, "a creative and democratic process of human development and self-realisation", or "potential for harm" varies with such factors as their socio-economic status, educational background, personal ideology and relative success or failure in society as it is.

4.57 While accepting that the State has a right to use the criminal law where there is strong evidence that certain behaviour has potential for harm to individual citizens and to the public interest in general, this committee would also suggest that the State has a *responsibility* to develop and use social and civil control procedures and sanctions whenever and in so far as these prove effective.

4.58 As the Le Dain Commission pointed out, the problem lies not only in the formulation of general principles but also in their application to the particular case, that is, to the illegal, non-medical use of drugs.

"Potential for Harm"

4.59 What for instance does "potential for harm" mean in this context? What sort of harm is involved and with what effect on whom?

4.60 Most people tend to think that "harmfulness" is inherent in the pharmacological properties of the drugs themselves so that, for instance, an opiate is absolutely more harmful in all circumstances than a barbiturate. But pharmacologists insist that the potential harmfulness of each drug can be meaningfully assessed only in the total context of its use. This means taking into account not only the pharmacological properties of the drug, though these are important, but also dosage, method and frequency of administration, the condition of the subject, what other medication he is receiving and its intercations, and whether he can tolerate or in some cases even survive the multiplicity of effects of the drug. Most important of all, it also involves the aim, knowledge and identity of the administrator, that is whether he is a qualified doctor or not.

4.61 First, the matter of dosage. All substances are harmful in sufficiently large doses, even water and oxygen. Many drugs which are livesavers in certain small doses and to certain people, for instance

adrenalin and digoxin, are lethal in larger doses and to other people. On the other hand, drugs which have a high potential for harm at a certain level of dosage do not necessarily produce the same effect in very low doses. Secondly, while some drugs may be harmful in single doses, especially large ones, others require repeated administration over a period, sometimes a long period, of time, before their adverse effects appear. There is indeed a difference between acute and chronic toxicity. Thirdly, whether a drug is taken by inhalation, ingestion, or intravenous injection significantly affects its action. Finally, the potential for harm of any drug, even an opiate, is greatly reduced when it is controlled by the knowledge, professional standards, and good judgment of a doctor, who should relate dosage, method, and frequency of administration to the required therapeutic end, duly weighing the beneficial against possible detrimental effects.

The patient takes no part in the decision-making but, if he is wise and well served, accepts the doctor's judgment as to when to take the drug and when to stop. But when drugs are used outside medical supervision for non-medical purposes, these safeguards and restraints are removed, as indeed they are in those cases where medical judgment is at fault. Administrator and recipient are usually the same person and the reasons for administration such that he is motivated to continue and perhaps to increase the drug rather than the opposite. Moreover several of the drugs commonly used illegally have little or no valid medical use.

4.62 Although it is commonly said that a particular drug, for instance morphine, has a high potential for harm in and of itself, it is more accurate and helpful to say that it has a high potential for harm to the recipient when administered outside medical practice for non-medical purposes especially by intravenous injection in doses of a certain level at too frequent intervals. Prescribed and used in a proper medical context, many commonly misused drugs are indispensable and entirely safe and beneficial, morphine being an excellent example.

4.63.1 Having clarified this point and emphasised the lack of controls implicit in the illegal, non-medical use of drugs, we can now more meaningfully recognise that there are significant differences in the potential for harm of the drugs used illegally and for the non-medical purposes *in their typical forms of illegal use.*

4.63.2 The opiates heroin, morphine, methadone, and pethidine, have in general a far greater potential for harm than cannabis, not only because they produce physical dependence if administered in sufficient doses for a comparatively short period, but because they are frequently injected intravenously. Also these drugs are more likely to be used by individuals on their own or belonging to a small closed circle in which their drug use is reinforced by the fact that it separates them from and so enables them to look down on the uninitiated majority. Opium, while also an opiate with the same capacity for producing dependence, has slightly less potential for harm when smoked or ingested, as it so often is.

4.63.3 Cannabis plant has a lower potential for harm because it is typically smoked in a way that greatly reduces the intake of the active principles of the drug by and in groups that use it as an aid to social enjoyment and interaction as much as for its intoxicating effects. There is strong reason to believe however that cannabis is potentially much more harmful when taken in other forms. (See section 7.)

4.63.4 Amphetamines and barbiturates, so often until recently treated as less harmful than cannabis plant, can be far more dangerous, particularly when used in conjunction with each other or with other drugs including alcohol, or injected as they often are in illegal use.

4.63.5 In the case of most drugs used illegally, users get "hooked" on the lifestyle and company that goes with their misuse quite as much as on the drug; such aspects of psychological dependence are far more difficult to deal with than physical dependence.

4.64 The people most obviously harmed by the illegal non-medical use of drugs are the users. Keeping in mind the differences in the potential harmfulness of different drugs in different contexts, there is plenty of evidence that users' physical and mental health and personality can all be affected in ways ranging from the minimal, through serious illnesses such as chronic dependence, damage to the liver and kidneys, and the precipitation of psychoses, to death through overdose, accident, or lethal serum hepatitis. In the case of the young, there is the added danger of retardation or disturbance of the maturation process. In particular, the non-medical use of drug in adolescence interferes often drastically with the process of learning to cope with stress. This applies to misuse of alcohol as well as to that of drugs legally limited to medical use.

4.65 Though some argue that the illegal user of drugs harms only himself, little thought is needed to show this up as a fallacy. In the first place, family members and close associates are likely to be upset by any obvious impairment of health and personality, with its detrimental effect on personal relations and on the fulfilment of obligations such as support of self and dependants. Furthermore, others may be injured as a result of actions committed under the influence of a drug through accidents with machinery, motor vehicles, or fire. The young and vulnerable may also be injured by being drawn into the non-medical use of drugs through the example or active aid and encouragement of those already involved. Lastly, there is harm to society and the public interest in general through withdrawal of productive services and pressure on health and welfare services.

4.66 The potential for harm of particular drugs must therefore be assessed with reference to harm both to the user and to others, including harm to other public interest. These are likely to be closely related, so that the greater the potential for harm to the user, the greater the potential for harm in other ways. There may, however, be exceptions as for instance when cannabis plant, which has a comparatively low potential for physical harm to the moderate user, increases the risk of accidents through its effect on time perception and driving skills.

4.67 Assessing the *amount* of actual harm as distinct from potential harm arising from the illegal use of drugs in New Zealand is an extremely difficult if not impossible task. Much illegal use of drugs remains hidden, together with its effects. Lack of practicable test procedures makes it difficult to prove when such use is involved in other offences and certain aspects of the harm caused, such as the effect on family members, is hardly amenable to measurement. If we take the only positive indications available to us, deaths, injuries to self or others, hospital admissions and convictions for crimes associated

with the illegal non-medical use of drugs, the overall number is fortunately, as yet, small especially when compared with those associated with the misuse of alcohol. Nevertheless, the record of at least 10 deaths in 1972 from synthetic opiates alone and the continuing escalation in hospital admissions and to a lesser extent in convictions for offences associated with drug misuse provides cause for serious concern, and a warning of what could happen if the problem is not contained.

Potential for Harm Versus Costs of Criminal Sanctions

4.68 The second major problem is determining whether the potential for harm associated with the non-medical use of particular drugs is sufficient to warrant the use of penal sanctions.

4.69 Potential for harm to the user would seem to be mainly a matter of medical concern. The difficulty in this connection arises from the fact that many of the users do not want and will go to great lengths to avoid medical intervention unless this affords access to supply. Some people including many police officers argue that legal sanctions are necessary to influence the unwilling to stop their misuse at least for a spell and to take treatment; others, including some doctors, have doubts about the lasting effectiveness of compulsory treatment. It is clear, however, that persistent misusers who will not take or profit by treatment, especially if they are active proselytisers, are a danger to others who are vulnerable for various reasons, especially the adolescent and the socially or psychologically inadequate or disturbed.

4.70.1 There are many activities which cause comparable harm to family and associates without attracting legal sanctions, for instance, adultery, compulsive gambling, gluttony, and excessive ambition. (It might surprise readers to discover how few of the seven deadly sins are statutory crimes, though they may have consequences which are.) Every year citizens seeking pleasure and relief from tension in the mountains or at sea place heavy pressures on public rescue and health services through their own fault in neglecting proper precautions, with little outcry that these forms of recreation should be banned on that account. The amount of actual injury that can be established as arising from actions connected with the illegal use of drugs in New Zealand is at present fortunately limited: we are still far removed from the situation that obtains in North America, where a substantial amount of crime including robbery with violence, shoplifting, and prostitution is committed in order to finance an opiate habit.

4.70.2 In the case of cannabis, however, many would argue, with a cogency we accept in large part, that disrespect for the law may well arise because the relevant statute puts cannabis on the same statutory footing as the opiates, when an increasing proportion of the general public considers it has a much lower potential for harm.

4.71 If the hazards to the user's health and consequent repercussions on his associates and health and welfare services were the only causes for concern, the committee feels that the problem of the misuse of drugs could be handled. In some cases, the misuse of drugs already constitutes a breach of ethics laid down by professional bodies concerned. As the matter stands, however, we consider there are two

powerful arguments for the *retention* of legal sanctions as an ultimate line of defence: first, the possibility of a rapid increase in crime of certain kinds if the illicit drug market became large enough to attract organised criminal entrepreneurs in this field; secondly, the need to protect the young and vulnerable from commercial exploitation and risk of harm when they cannot foresee the consequences. At the same time, we are aware that, because of the high proportion of young people involved, the use of legal sanctions may bear unevenly on some of the very people they are intended to protect. This is a major reason for our stress on the development of alternatives to legal sanctions.

4.72 As the Le Dain commission pointed out in their interim report, the use of the criminal law has its own costs, and these must be weighed against the potential for harm of particular drugs. The greatest of these costs is the effect of court convictions on young lives: reduction of vocational opportunities, loss of reputation, and limitation of rights such as that to travel overseas, and the mental suffering of the offender and his family. Secondly, there are the costs of law enforcement and punishment: the costs of employing police, probation, and prison officers for this purpose, and the costs of keeping offenders in prison. Thirdly, legal sanctions may make it more, rather than less, difficult for users to overcome entrenched patterns of misuse, and for the doctors and other workers trying to help them, since the threat of penal consequences may exacerbate the states of mind—anxiety, self-doubt, feelings of persecution, and pehaps depression—for which they are accustomed to seeking relief through drugs, and a conviction may also affect ability to find employment, a key factor in rehabilitation. Fourthly, opponents of sanctions on the use of cannabis claim that they force people interested only in cannabis into contact with suppliers dealing in many drugs, and so expose them to pressures to try others. Fifthly, when the incidence of a particular kind of illegal behaviour becomes so relatively common and widely tolerated that the police can bring only a small proportion of offenders to court, such partial enforcement it is claimed creates feelings of injustice and victimisation in those prosecuted. This has become the case with cannabis in certain groups in some overseas countries. It could become so here but this is still far from being the case at present, having regard to the number of cases brought to the courts and the assessed ratio of undetected to detected offences.

4.73 In its Cannabis Report, 1972, the Le Dain Commission stressed the importance of balancing the potential for harm involved in the non-medical use of drugs against the harm caused by the use of the criminal law, not only in general, but with regard to different drugs and types of drug use. "The criminal law may properly be applied, as a matter of principle, to restrict the availability of harmful substances, to prevent a person from causing harm to himself or to others by the use of such substances, and to prevent the harm caused to society by such use. In every case the test must be a practical one: we must weigh the potential for harm, individual and social, of the conduct in question against the harm, individual and social, which is caused by the application of the criminal law, and ask ourselves whether on balance, the intervention is justified. Put another way, the use of the criminal law in any particular case should be justified

on an evaluation and weighing of its benefits and costs. Generally speaking, the adverse effects of the criminal law process on the individual are such that it must be justified in each case by rational and convincing reasons of necessity, in relation to other available means of achieving the desired purpose." (Le Dain Commission Cannabis Report: 282–3.)

4.74.1 On this basis—that the costs of criminal sanctions outweighed the potential for harm of cannabis—three members of the Le Dain Commission recommended in the Cannabis Report, 1972, that the penalty of imprisonment for the simple possession or use of cannabis be removed from Canadian law, while the imprisonment penalty for trafficking and for cultivation and possession for the purposes of trafficking be retained. One member favoured the retention of the penalties for possession and use while, on the other hand, the fifth advocated introduction of legal control of the sale and use of cannabis. Some months later the United States National Commission on Marihuana and Drug Abuse recommended lifting the legal sanctions against private possession and use, while continuing to penalise public use and trafficking. This recommendation was made, a fact which is often overlooked, within the context of a policy of *firm discouragement* of marijuana use. Neither of these bodies, nor any other, has suggested that criminal penalties be lifted for the possession and use of other controlled substances.

4.74.2 In the United States Presidential election, 1972, the State of California had, in its voting papers a proposition 19, which reads:

> "Removes State penalties for personal use. Proposes a statute which would provide that no person 18 years or older shall be punished criminally or denied any right or privilege because of his planting, cultivating, harvesting, drying, processing, otherwise preparing, transporting, possessing or using marihuana. Does not repeal existing, or limit further legislation prohibiting persons under the influence of marijuana from engaging in conduct that endangers others. Financial impact: None."

Contrary to expectations fostered by a strong pro-legalisation lobby this proposition was rejected by the electorate by 70 percent to 30 percent.

4.75.1 In the task of weighing the potential for harm of the illegal non-medical use of drugs against the costs of legal sanctions in New Zealand, the Committee considers it is impossible to make a fully objective assessment of each of these aspects, because there are too many imponderables involved. At present we simply do not know the precise answers to some key questions. In particular we would like to know how effective the existing laws have been in limiting the spread of the illegal use of drugs. There has been a considerable increase in its detected incidence in New Zealand since 1965, the year in which the Narcotics Act replaced the Dangerous Drugs Act, with among other things a further *reduction* in the maximum penalties provided, a fact which is often overlooked. This increase cannot, however, be interpreted as evidence that the newer less rigorous law has been ineffective, because it is obviously part of a world-wide trend that many other countries also have failed in varying degrees to contain. Would the increase have been greater if it had not been for

the deterrent value of the drug laws and their enforcement? Or has enforcement of these laws been partly counter-productive, either through increasing the pressures (real or perceived) that lead certain people to seek relief in drugs or through investing the illegal non-medical use of drugs with a certain amount of glamour and symbolic significance as a form of rejection of "establishment" patterns of behaviour and morality? Have the newer penalties been a factor? We don't know at this stage.

4.75.2 A significant connection could be assumed between the extent of public support for particular legislation and its effectiveness as a deterrent. As attitudes to the use of cannabis become more lenient in some quarters and use more common, the police are able to apprehend a smaller proportion of offenders. This undoubtedly diminishes the impact of the law as a deterrent, but by no means eliminates it. An extremely important question is the extent to which the law is seen as a guide to morality by ordinary citizens as distinct from the legal philosophers. If they tend to regard as really "bad" only those actions which there is a law against, there is a danger that lifting the sanctions against the possession and use of cannabis would be interpreted as an expression of official approval; an admission indeed that the misuse of certain controlled drugs is not particularly dangerous, and so lead to a lessening of general moral disapproval followed by an upsurge in misuse not only of cannabis but also of more harmful drugs.

4.76 With regard to the proposals of the Canadian and United States commissions concerning the possession and use of cannabis, the committee sees some practical difficulties in maintaining a policy of firm discouragement in the absence of at least some formal sanctions when use is as widespread and socially tolerated as is reported for North America. It could also be argued that the full weight of penalty should not fall on the dealer alone, when his activities depend on the existence of a demand provided by users who, after all, break the law knowingly. Besides, distribution methods for cannabis are such that it is by no means easy to separate dealer from user especially at the middle and lower levels of the supply chain. The committee is restrained by four main considerations from recommending the complete repeal of penalties for the possession and use of cannabis plant, that is marijuana, even in private. In the first place, what evidence is available to us suggests that the extent of marijuana use and its toleration by the general public, though considerable in some quarters, is still far less extensive than in North America. Secondly, whereas it may be true, as the National Commission suggest in *Marijuana: A Signal of Misunderstanding,* that marijuana usage has passed its peak in the United States, the present situation in New Zealand is such that the removal of legal penalties would almost certainly result in a substantial increase in use, an increase we would view with alarm, for the reasons set out at length in section 7.33 to 7.35. Thirdly, though marijuana users do not automatically or even in most cases proceed to other types of drugs, there is a very considerable risk of their proceeding to more potent forms of cannabis, that is to hashish and THC, both of which have a much greater potential for harm than cannabis plant. Fourthly, if the removal of penalties was followed by a marked upsurge in the use of marijuana and other forms of cannabis and any demonstrable increase in harm through driving

accidents, delayed maturation, diminished initiative, or precipitation of psychosis in the psychologically vulnerable, it would be difficult if not impossible to recover lost ground, and there would undoubtedly be a public clamour for the institution not simply of former controls but of more stringent ones.

The Committee's Position

4.77 On balance then, the committee considers that the pontential for harm from the illegal, non-medical use of controlled drugs is great enough, especially in the case of the opiates, LSD, and the central stimulants, and uncertain enough in the case of cannabis plant, to warrant retention of legal sanctions, as a last resort, in order to contain the escalation of drug misuse in New Zealand. However, we consider that the existing New Zealand legislation dealing with the control of drug use is due for consolidation and revision.

4.78 From the evidence of many witnesses, it has been borne home to us that the making of a formal distinction between controlled drugs with different potential for harm, and especially between cannabis plant and the opiates, has important symbolic significance. The fact that the existing legislation does not formally make such a distinction and classifies cannabis as a "narcotic" has been interpreted by many as failure to recognise that such a distinction exists and as evidence either that the "establishment" is too out-dated in its attitudes and knowledge to be worth listening to on the subject of drugs, or that the drugs involved are in fact interchangeable. The fallaciousness of these conclusions does not unfortunately diminish their dangerous implications. Since the study of sentencing patterns indicates that the judiciary is already making distinctions between drugs of different types in practice, we can see important advantages and no obvious disadvantages in making such distinctions explicit in the legislation.

4.79.1 Accordingly, we recommend that the "blanket" provisions of the existing legislation be replaced by a more flexible system of scheduling drugs liable to misuse which would broadly take account of their relative potential for harm in the context of misuse. We further recommend that cannabis plant be distinguished from cannabis resin and extracts and placed in a category of lesser or least harmfulness. We also consider that provision might well be considered for the intravenous injection of any drug used for non-medical purposes to attract heavier sanctions than when it is taken orally. Finally we recommend that the existing maximum penalty for the offences of possession and use—3 months' imprisonment or $400—be retained and that maximum penalties be attached to the various categories of drugs in such a way as to ensure that offences relating to drugs in the categories of lesser or least harmfulness, should incur an imprisonment penalty only in exceptional circumstances. We would like to see the degree of persistence in drug misuse and the amount of harm actually caused also taken into account in imposing penalties, but consider this would be better left to the discretion and wisdom of the courts.

4.79.2 We recognise, however, that there may be strong pressures to increase the penalties for drugs in the most strictly controlled group, particularly heroin.

4.80 However, although we have recommended retention of the legal sanctions on the misuse of drugs, we should like also to press for the development of alternatives to legal sanctions which would hopefully reduce the number of offenders reaching the courts. We cannot stress too strongly our belief that legal sanctions should be used as sparingly as possible, when other measures have been tried and failed.

Alternative Sanctions

4.81 While the illegal non-medical use of drugs commonly involves considerable harm to others and to the public interest the greatest harm is normally to the user himself. Now it could be argued that if an adult accepts the advantages of living in a certain social order, he has a responsibility to make a contribution in return through participation in productive activities, through taxes on his earnings and perhaps through other services. In the middle ages deliberate self-injury was punished under the old law of mayhem—"depriving the sovereign of his right to military service". While we can see some moral justification for this view we would be most reluctant to see the State build such a principle explicitly into its laws, believing that the modern State has to accept a measure of responsibility for those of its citizens who are handicapped physically, mentally, or socially and to accept a reasonable degree of non-conformity. For it is no easy matter to decide when a person's misfortunes are his own responsibility and when they stem from influences beyond his control or from the inadequacies of the system itself. We feel that the most cogent argument for taking steps to prevent people injuring themselves through the misuse of drugs is embodied in the famous passage from one of John Donne's sermons: "No man is an island, entire of itself, every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less as well as if a promontory were, as well as if a manor of thy friend's or of thine own were; any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."

4.82.1 However, whether the aim is to protect the individual or society, there are kinder and more effective methods than reliance on the criminal law alone to deal with the misuse of drugs. Many other educational, therapeutic, and social and supportive measures are needed to a much greater extent than was hitherto the case. Certain non-criminal procedures are already available and in use under the Mental Heath Act, and the Alcoholism and Drug Addiction Act, which enable relatives, doctors, or the subject himself to initiate committal (where justified) to a psychiatric hospital or ward for treatment.

4.82.2 The Alcoholism and Drug Addiction Act as it stands has certain unsatisfactory features. The committee would support any move to revise this Act (including a change of name) and would hope that in any revision full cognisance would be taken of the philisophy and recommendations, where relevant, in this report.

4.82.3 However, by no means all those who require treatment for alcoholism or drug misuse present significant psychiatric problems of a type that specifically require impatient treatment in a psychiatric hospital or ward.

4.82.4 The committee suggests that any revision of the Act should provide for treatment or management to be given whenever appropriate at approved hospitals, both general and psychiatric, and at other approved treatment agencies. Use might be made, with some modification, of the provision in the Mental Health Act for single patient committal to the care of a relative or other person while undergoing out-patient treatment. The committee, however, recognises that such arrangements are fraught with difficulty and are dependent for success on a concordance of motivation which, is apt to be rare and hard to come by in the drug situation.

4.83 While in themselves non-penal statutes (though they may be invoked by a magistrate in lieu of legal penalty), both the Mental Health Act and the Alcoholism and Drug Addiction Act amount in application to a benevolent coercion of an unwilling patient in his own interests. If drug taking is giving a person more pleasure than any other activity in what is often subjectively felt to be a somewhat miserable existence, he will understandably resist any attempt to get him off drugs. Unlike someone acutely distressed by a painful malady like gout, he has little incentive to seek treatment, at least not until his drug misuse begins to have quite serious adverse consequences to health and ease of living, and sometimes not even then. Should he be forced to accept treatment? It must be admitted that the results of various forms of treatment for drug dependents are all too often disappointing, but this is largely because of this very factor, the patient's lack of motivation. As with the person who is psychotic or otherwise mentally ill, the patient's wishes have to be offset against the welfare of the community, and on occasions a misuser of drugs may have to be hospitalised against his will for his own sake and for the sake of others. However, if a person is to be coerced in this way, great care must be taken to ensure that the particular case warrants such action; and the treatment regime should, within the limits of what is possible, aim to enlist the initially unwilling patient's co-operation.

4.84 There is a clear need for measures which place more emphasis on persuasion and co-operation than on coercion and which might have some prospects of reaching drug misusers before they themselves attain the stage of needing hospitalisation, or attracting the attention of the police to the point at which the laying of a charge is inevitable.

4.85 The committee has spent some time in the consideration of possible measures of this sort, including a proposal for increased participation of the medical officer of health and his staff in identifying those engaged in the non-medical use of drugs and advising them of treatment opportunities. However, we realise that the detailed development of this and other measures is beyond our competence, clearly calling for the pooling of the experience and ideas of those directly involved in dealing with drug misusers and those responsible for the administration of laws relating to drugs. Accordingly, we recommend that the Department of Health seek an early opportunity for consultation on this need with various professional organisations, health authorities and social agencies concerned.

4.86.1 Where a person involved in the illegal use of drugs comes to the notice of the police, it remains desirable, as we have already

indicated in our first report (8.11), that the police should have, and use, a degree of discretion in deciding what action to take. It is hoped that they will make increasing use of alternatives to prosecution in appropriate cases, especially where the offender is young and/or there is a good chance of diverting him from the misuse of drugs towards treatment or other interests. However, we recognise that such a course involves difficulties. In particular, those who embark on a course of action under threat of prosecution are less likely to possess any strong drive to pursue it successfully. Many are almost certain, at least initially, to distrust any organisation, whether official or independent, to which their attention is directed by the police, suspecting a feedback of information, particularly about their lapses. These problems can however be overcome we believe by the exercise of good sense and sympathetic handling by the police and the staff of the agencies concerned.

4.86.2. Despite the suspicions of illegal drug users, it should be pointed out that hospital and other treatment agencies have strict rules governing the release of information about patients to outsiders, including the press and the police. The Hospitals Act 1957 actually makes it an offence to disclose information about a patient without his consent or that of his representative. However, it does provide for certain exceptions, including the information required by a police officer in the course of investigating a known offence. Even in this case, the disclosure must be authorised by the hospital superintendent. In practice, hospital and other treatment agencies typically resist outside enquiries with vigour where they are likely to interfere with the well-being or progress of their patients.

4.87.1 On its side, the Police Department does not permit its officers to make inquiries at hospitals and other treatment centres regarding a patient's misuse of drugs with the intention of initiating proceedings against him solely on that evidence. A police officer may legitimately seek information from hospital staff only in connection with a breach of the law for which other evidence is available. Accepting the principle that treatment and rehabilitation are of primary importance, the Police Department directs its officers to refrain from interfering with known drug misusers who undertake a treatment or rehabilitation programme as long as they do not continue to commit drug offences or are not found to have been parties to some serious offence such as dealing or burglary. In such cases, they cannot expect an immunity from police inquiries that is not available to other patients.

4.87.2 Similarly the Department of Health maintains strict confidentiality of all information received by its Narcotics Control Section, storing it in locked cabinets, separate from other records and under the direct personal supervision of a senior officer. Access to this information is extremely restricted. Moreover, no officer of the Department of Health is employed in the day-to-day running of the National Drug Intelligence Bureau, which is staffed entirely by members of the Police and Customs Departments. The Director-General of Health or his nominee, however, is a member of the board responsible for the direction of the National Drug Intelligence Bureau and liaison is maintained through the executive officer of the Narcotics Control Section, Department of Health.

4.88 Finally, we would stress that one of the most effective sanctions will always lie in the provision of good, soundly based, unemotive educational programmes within the broader context of healthy living, aimed at moderating the overall use of chemical substances in our lives, including alcohol, tobacco, tranquillisers, and sedatives. The achievement of such attitues of moderation as a norm in our society would, it is believed, do more to reduce the illicit misuse of drugs than over-reliance on criminal sanctions by themselves. The committee, however, recognises that in dealing with offences of illegal distribution and supply it will always be necessary to maintain unceasing vigilance, adequate and effective sanctions, and full recourse to the courts.

V. INTERNATIONAL ACTION

4.89 The first report of the committee made mention of then current action to amend international instruments which control narcotics and psychotropic substances. Since that time a United Nations Conference held in Vienna during January and February 1971 completed the Convention on Psychotropic Substances 1971 and another United Nations Conference at Geneva during March 1972 prepared a Protocol Amending the Single Convention on Narcotic Drugs 1961. Such instruments become undertakings by parties on the general and sometimes particular policy they will adopt in the control of drugs, the attitudes they will take in dealing with unauthorised producers and suppliers, and the manner in which they will treat misusers. It is within the competence of any country to decide on a more rigorous internal policy, but by becoming a party to the Conventions and adopting and enforcing minimum standards it reduces the incentive for drug abusers to seek refuge in, and economic dependence on, that country and reduces, and hopefully eliminates, the country becoming a source of illicit supply to other countries. Some delay must be expected before these instruments become effective. Following its usual practice New Zealand will adapt its law and administration to achieve the minimum requirements before it will ratify the Convention or Protocol and is moving towards this position. The instruments do not come into force until the required number of states have become parties.

The Convention On Psychotropic Substances 1971

4.90. While the existence of the Convention on Psychotropic Substances is welcome, it is foreseen that it may need strengthening from time to time. It fails to apply some of the lessons which should have been learned from the operation of the Opium Conventions of 1912 and 1925, and which demonstrated the need for the provisions added by the Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs 1931 and various other Protocols, and subsequently incorporated in the consolidating Single Convention on Narcotic Drugs 1961. The controls it requires to be applied on production, international trade and internal control are unlikely to prevent or reveal the full extent of determined diversion from legitimate production and distribution to illicit channels of supply and use. The drugs to which it applies are those of which there is widespread knowledge and experience of abuse but it does not extend to known congeners which by reason of

similar pharmacological action or chemical structure are likely to have similar potential for abuse, nor to substances of which abuse experience is only regional or sporadic. This Convention is, however, meritorious for the emphasis it places on responsibilities to provide education aimed at informed avoidance of drug misuse and abuse, and for regarding the treatment and rehabilitation of abusers as more important than their punishment.

4.91. Four regimes of control are provided for. Recognising the weaknesses already commented on, lysergide, all tetrahydro-cannabinols, and a number of other hallucinogens would be subject to more rigorous control than under the Single Convention on Narcotic Drugs; a number of amphetamines and similar substances, and phencyclidine, would be subject to conditions similar to those applying to narcotic drugs; a few barbiturates and glutethimide to lesser control; and a few barbiturates and a few central nervous system depressants subject to quite minor restraints. It is conspicuous that the central nervous depressants which have the most widespread use, misuse, and abuse in many countries of the world are not included under the Convention at all. A number of countries have already applied a great deal of control on these drugs and some have declared their intention of initiating the steps, when the Convention comes into effect, towards applying it to them. (Appendix VIII.)

The Protocol Amending The Single Convention On Narcotic Drugs 1961

4.92 A large part of the Protocol Amending the Single Convention on Narcotic Drugs 1961 relates to administrative and technical matters which do not materially affect New Zealand but should improve the effectiveness of the Convention. The Protocol does, however, recognise and promote the changes of attitude of the past decade by modifying the obligation to punish offences, in some circumstances "particularly by imprisonment or other penalties of deprivation of liberty" with a proviso:

> ". . . when abusers of drugs have committed such offences, the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration. . . ."

It further provides that:

> "The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.
>
> "The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of drugs.
>
> "The Parties shall take all practicable measures to assist persons whose work requires to gain an understanding among the general public if there is a risk that abuse of drugs will become widespread."

In this wording the Protocol is similar to the Convention on Psychotropic Substances. (Appendix VIII.)

The Status Of Cannabis

4.93 The community of nations was well aware prior to and at the Conferences both at Vienna and Geneva that there existed two opportunities to alter the status of cannabis. The matter was discussed and considered at Vienna but it was agreed to make no change; it was raised but not further pursued at Geneva. There was a recognition that the provisions being written into Convention and Protocol and quoted above appropriately modified obligations in the light of existing knowledge.

Education

4.94 Having received reports from the World Health Organisation, the Commission on Narcotic Drugs, and the International Narcotics Control Board, the United Nations Economic and Social Council invited the United Nations Educational, Scientific, and Cultural Organisation to contribute by collaboration with the other bodies in those areas, particularly of education, within its ambit. Numerous approaches to education have been explored and applied in different countries with mixed results. It is expected to be some time before they can be evaluated and the findings applied.

Drug Abuse Control Fund

4.95 During 1971 there was established a United Nations Fund for Drug Abuse Control. Some members of this committee were privileged to discuss various matters with Mr Carl Schurmann, the personal representative of the Secretary-General of the United Nations as director of the Fund when he visited New Zealand. This country has pledged three annual contributions of $15,000.

4.96 The United Nations Plan for Concerted Action Against Drug Abuse will be financed from this Fund. The Plan at present includes 106 projects, the most important of which aim at instituting viable crop substitution schemes to replace illicit opium and cannabis production, the training of government officers of less developed countries in drug control measures, the promotion of regional co-operation in drug control, and the development of educational programmes towards avoiding drug misuse and abuse. New Zealand cannot properly expect direct advantage from these projects but may reap indirect benefits through a diminution of illicit traffic, greater interception in transit to this country, and some evaluation and useful guidance on educational programmes.

Information Centres

4.97 Not always within the terms of reference of this committee, but at least peripheral to the matters it has been called on to consider, are several developments, commenced nationally by a number of countries and now being co-ordinated and promoted amongst all countries by World Health Organisation, relating to drugs and aimed at identifying, measuring, and overcoming the problems they have created. New Zealand is already involved in such things as a poisons information and control centre, adverse drug reactions reporting and monitoring, evaluation and screening before release of new drugs, advertising and suppression of unjustified, false, incomplete, and misleading drug advertising, and the institution of good manufacturing practice and quality control of drugs. It can be foreseen that while some of these projects can be accomplished administratively others will involve legislative and regulatory changes.

Recommendations

We recommend:

1. That legislation relating to the control of drugs and similar substances (other than alcohol and tobacco) which have a significant potential for misuse should be incorporated into a single statute.

2. With regard to the provision and presentation of such legislation, we recommend:

(a) That the term "narcotic" should be avoided as far as possible or used only with its pharmacological meaning.

(b) That the drugs controlled be placed in several separate schedules (or parts of one schedule) which broadly indicate their relative potential for harm and degrees of control deemed necessary.

(c) That cannabis plant, but not cannabis resin (hashish) or extracts of cannabis, should be placed in a schedule (or part of a schedule) containing drugs with a lesser potential for harm.

(d) That differing maximum penalties, graded in severity, be provided for offences involving the possession or use of different drugs as scheduled in terms of their relative potential for harm.

(e) That the maximum penalty for the possession and use of drugs with the highest potential for harm should not be greater than the present maximum penalty for all cases of possession and use of controlled drugs.

(f) That the present policy of providing higher maximum penalties for offences of dealing in controlled drugs than for possession and use be maintained, but that differing maximum penalties, graded in severity be provided for dealing offences in terms of the relative potential for harm of the drugs concerned.

(g) That the maximum penalty for dealing offences involving drugs with a high potential for harm should not be greater than the present maximum penalty for all offences of dealing in controlled drugs, and that maxima for dealing offences involving drugs in schedules of lesser harmfulness be lowered where appropriate.

(h) That consideration be given to the suggestion that the illicit use or administration by injection of a drug prepared for oral use should be deemed to place it in a category of greater harmfulness carrying a higher maximum penalty.

(i) That a definition of "supply" and quantities of drugs, the illicit possession of which raises a presumption of dealing, should be made; and that, furthermore, smaller quantities should be set for those drugs having the greatest potential for harm, having regard also to the level of effective dosage involved.

In addition, for the consideration of the courts:

(j) That except in most unusual circumstances a penalty of imprisonment should not be imposed for the mere possession or use of a drug in a schedule of lesser harmfulness.

3. We further recommend:

(a) That provision be made for periodic review, in the light of developing understanding of drugs and of drug misuse, of both the classification of drugs and of the penalties which their illegal production, distribution, possession and use may attract.

(b) That consideration be given to a review of the Alcoholism and Drug Addiction Act with the intention of adapting its provisions more closely to the changing situation in the field of drug misuse, with special reference to surveillance to follow supportive measures when need for inpatient care does not apply. (Section 10.)

(c) That the Department of Health take the initiative in exploring the development of non-legal sanctions against the misuse of drugs, with particular reference to the suggestions in section 4, paras. 82–88.

5. PRESCRIBING, DISPENSING, AND PROMOTION

I. PRESCRIBING AND RELATED PROBLEMS

5.1 We have already dealt fairly fully with questions of prescribing and sources of supply in section 7 of our first report. In that section we pointed out that the continual discovery of new and potent drugs, while of inestimable benefit to mankind through the relief of suffering, also brought problems in its train through the diversion of drugs to non-medical purposes and, even more seriously, as a result of the rapidly increasing tendency to accept drugs as an essential part of everyday life to be resorted to without delay as a panacea in the event of pain, stress, or discomfort. We explored the strength and effects of patient demand for drugs and the various factors, including their heavy work load, which inclined doctors to over-ready prescribing, the related problems of the "conning" of doctors and the hoarding of unused prescriptions, the education of doctors in the use of drugs, and the functions and responsibilities of the Department of Health and the Medical Association of New Zealand with regard to the maintenance of professional standards including any necessary action. We would still stand by most of what we wrote in this section: instead of repeating it here we refer readers to it. There are, however, certain points we should like to make in clarification, amplification, and commentary on our earlier statement.

5.2 In the first place, we should like to stress that our comments on over-prescribing were certainly not intended as a blanket criticism of all doctors. When we wrote in paragraph 7.6 that "The regular prescription of drugs is not a satisfactory substitute for the more time-consuming practice of listening, assessing, and establishing an effective doctor-patient relationship", we did not intend to imply that all regular prescription of drugs was wrong and necessarily indicated a failure to establish "an effective doctor-patient relationship". We are well aware that in many cases doctors choose this course, after a most thorough investigation for good reasons: where for instance a chronic condition such as diabetes or epilepsy is involved; where it is wise to take quick preventive action (with children for instance, lest they are incubating something serious like meningitis), or where it is a matter of psychological illness, the roots of which lie too deep in childhood traumas to be speedily uncovered. We also recognise that doctors take practical difficulties on the part of the patient into account, as when they prescribe an extended supply for patients handicapped by age and infirmity, distance or limited income, in order to reduce the number of visits to or by the doctor. We agree that it is the prerogative of the doctor concerned to decide whether a particular patient needs and will benefit most from psychological or spiritual help, reassurance, or sedatives and tranquillisers. At the same time, for the sake of patients, there must be some supervision of professional standards and practice.

5.3 As a direct result of recommendation 4 in the first report, a new section (42A) was inserted in the Medical Practitioners Act 1968. This authorises a medical officer of health to lay a complaint with the Medical Practitioners Disciplinary Committee if, from his inquiries, he believes a doctor is prescribing excessively or irresponsibly. The committee finds that effective use of this provision is being made by the

medical officers of health. In most cases the offending doctors seem to have been unaware of certain aspects of the law, and have altered their prescribing patterns as soon as the matter was brought to their attention. The new section has thus resulted in improved communication and practice, even though disciplinary actions have not increased significantly.

5.4 The committee accepts that most doctors select the appropriate treatment for their patients and prescribe responsibly. We also believe that they are becoming increasingly aware of the need to inquire into the motives of patients, especially new ones, asking for particular drugs. Since the first report was published, we have been heartened by the way the official publications of the Medical Association of New Zealand have campaigned for greater care in this regard and the response of most medical practitioners.

5.5 In this connection, the committee also commends the Pharmaceutical Society and the Chemists Guild for the way they have briefed their members on their responsibility to detect and suppress irregularities in the prescription and supply of drugs to the public. The alertness shown by their members in consequence has greatly reduced the quantities of drugs diverted to illicit channels of distribution.

5.6 We believe that prescribing practice is such a crucial issue that it must be kept under constant review. We would urge the medical and clinical schools, the professional associations, and the Department of Health continually to impress upon the attention of doctors, pharmacists, and the general public the need for unremitting vigilance.

5.7 We would also hope that within the Department of Health the computerisation of the records of the prescribed drugs supplied under pharmaceutical benefits will be completed as soon as possible and adequate computer and staff time made available in order that prescribing patterns may be monitored and the extent and sources of over-prescribing be identified much more effectively than at present.

5.8 With regard to the prescription of amphetamines, the committee notes with approval that the Royal College of General Practitioners and at least one Medical Association of New Zealand division adopted a voluntary ban even before the stricter official controls referred to in section 4.41.2 were introduced in 1972, and that the quantities prescribed have fallen markedly. A further point noted by the committee was the relative absence of any evidence of upsurge in illicit traffic in these drugs since the restrictions were introduced. The committee recognises that there still maybe a few cases in which amphetamines are useful in legitimate therapy, so that a total prohibition is not advisable, at least in the meantime.

5.9 Since the first report the committee has become gravely concerned about some aspects of the treatment of drug dependent persons and more especially persons claiming to be drug dependent by a minority of doctors in private practice, especially the prescription of drugs, such as methadone and palfium, which themselves induce dependence. We are aware of situations where quantities of such drugs prescribed in this way have been diverted to illicit use and may have resulted in a significant number of avoidable deaths in young persons. As the law stood early in 1973, there were insufficient controls or limitations on the prescription of these drugs for the purpose of treating

drug dependent persons and, as many medical practitioners have found, their use in general practices is fraught with difficulties. We have reviewed the whole question of the use of methadone in the treatment of drug dependence in section 6. Here we will say only that for any chance of success its prescription in this context must be associated with thorough assessment, including laboratory investigation prior to offering methadone, and continuing supervision, counselling, and support by social workers during and after treatment. These are conditions that the general practitioner is virtually unable to meet. We acknowledge that some of the doctors who have attempted such treatment have displayed an awareness of the problems of drug-dependent persons and a desire to help that, in a better organised and disciplined setting, could be more likely to attain success. It is nevertheless desirable in the opinion of the committee (for reasons set out more fully in section 6) that the right to prescribe certain drugs for the treatment of drug dependent persons should be restricted by regulation to approved doctors operating in a suitable context such as an approved hospital or authorised treatment facility. We have already made our views known to the Department of Health on this issue and we understand at the time of writing that regulatory changes are in the process of being made. The therapeutic needs of individual drug-dependent persons could still be met in some cases by individual doctors on the authority of the medical officer of health, and the development of enlightened, responsible, and diversified therapeutic centres for the treatment of drug dependent persons is to be encouraged.

5.10.1 We have included as appendix XII the study by Dr A. W. S. Thompson of prescribing of hypnotics and tranquillisers. Dr Thompson found that in an average 24-hour period in 1971, 1.96 percent of the population (about 56,000 people) took a hypnotic prescribed by a doctor, and 3.7 percent took a tranquilliser. The corresponding figures for married women (or widowed, separated, or divorced) were 4.9 percent and 8.3 percent respectively. One-third of those taking hypnotics in this group, were taking them regularly and for long periods of time. On an average day, 5 percent of the whole population took a tranquilliser, a hypnotic, or both. The corresponding figure for married (or widowed, separated, or divorced) women was 11.6 percent.

5.10.2 He also found that the introduction and massive use of tranquillisers has done nothing to reduce the prescribing of hypnotics, which indeed almost doubled in 13 years. Doctors who were heavy prescribers of hypnotics also used more tranquillisers, and those who ordered fewer hypnotics tended to use fewer tranquillisers. Dr Thompson found that 39 percent of doctors were still prescribing a hypnotic which was the subject of a strongly worded warning to doctors just over a year previously, and that this drug was in fact the third most frequently ordered of all hypnotics. "A good example", he comments, "of the triumph of promotion over good sense".

5.11 Both before and after the first report was published, oral and written submissions have emphasised the widespread habit, especially among older folk, of hoarding the unused remains of prescribed medicines. It would seem relatively common for patients to uplift a repeat prescription when they still have all or part of the previous supply in their possession. A significant number of shy or

elderly persons seem to continue accepting new prescriptions from their doctor rather than admit to him that they have not taken their medicine as instructed. The answer to this problem lies in the first place with the prescriber, who should take great care in wording the directions to be written on the label and check by periodic inquiry whether the patient has understood the instructions properly. Common factors in misunderstanding are the failure of hearing and sight with old age, a limited command of English in the case of some immigrants, and even occasionally inability to read. In addition, however, there is a need for those around a patient who is elderly or a member of an ethnic minority—relatives, close friends, district nurses, and the like—to be more than ordinarily perceptive in this regard and to keep a concerned eye on the situation.

5.12 More clearly expressed information and advice should be included in instructions to patients of the potential effects of certain drugs on driving capacity and comparable skills. Many drugs which do not impair driving skills when taken alone may cause quite serious impairment when taken in combination, increasing each other's effects on co-ordination, perception, and reaction time. In particular, certain drugs such as tranquillisers, barbiturates, and many antidepressives reinforce the effects of alcohol, which in itself constitutes a major cause of serious accidents. Where relevant, instructions to patients should include a warning of the adverse effects on driving skills of combining the prescribed drug with certain others, particularly alcohol.

5.13 Information available to the committee at the time of the first report led it to comment that some hospitals in 1969 appeared to be discharging patients with over-generous supplies of drugs. The Department of Health subsequently drew the attention of hospitals to this matter and a survey was carried out in Dunedin. Some of the findings were contrary to expectation. Very few patients were found to be leaving hospital with sedatives and hypnotics on which they had not been established before admission. The committee feels that several more such surveys should be carried out in other areas with special emphasis on dependency producing psychotropic substances and opiates. It considers that surveillance of this kind is an essential and ongoing part of hospital management and that only a very modest demand on the time of suitably trained staff would be involved.

II. MEDICAL ADVERTISING—PHARMACEUTICAL PROMOTION

5.14 The Food and Drug Act 1969 defines "advertisement" as any words, whether written, printed, or spoken, and any pictorial representation or design used or appearing to be used to promote the sale of any food or drug or medical device or the use of any method of treatment and includes any trade circular, any label, and any advertisement in any trade journal.

5.15 A "medical advertisement" is defined as an advertisement relating to or likely to cause any person to believe that it relates to any drug or medical device or method of treatment. Section 10 of the Act details certain prohibitions on medical advertisements while section 11

gives exemption to any advertisement which is distributed only to the members of specified professions or published in magazines which are mainly circulated to members of those professions. The provisions of this Act restrict the form and claims of medical advertisements in regard to standards, strength, purity, and indications of prevention, alleviation, or cure of diseases which are specified by name in Part I or Part II of the First Schedule.

5.16 There are also voluntary controls on advertising such as those laid down by the New Zealand Broadcasting Authority which not only impose the necessity of complying with any legislation, but also include a statement with particular reference to the advertising of drugs: "Advertisements shall not directly or indirectly advertise any of the following products—tranquillisers, sedatives, nerve stimulants or any other form of therapy which is authoritatively considered to be of dubious benefit or propriety". Press rules appear to have somewhat similar restrictions but each advertisement is individually assessed. The Pharmaceutical Manufacturers Association has also issued advertising directives in its "Code of Practice For the Pharmaceutical Industry".

5.17 The effects of legislation and voluntary restrictions have reduced significantly exuberant public advertising of non-prescription drugs in this country. Nevertheless, although the Food and Drug Act 1969 strikes at publications and "publish" is defined sufficiently widely to cover some dealings by persons in New Zealand in imported literature, unfortunately many such papers, magazines, and periodicals escape the restrictions, and proprietary preparations of doubtful quality and efficacy are advertised in them to the possible detriment of susceptible members of the public.

5.18. It could well be that wider applications of the directives contained in the Broadcasting Authority rules, with particular emphasis on the statement " . . . which is authoritatively considered of dubious benefit or propriety" would help to curb the trends to a "chemophile" society without unduly onerous restrictions on the right to advertise.

5.19 In this age of the advertising consultant, the original concept of advertising as a means of communication between seller and consumer has changed to that of creating a demand for a product. Nowhere is this more apparent than in the field of pharmaceutical promotion.

5.20 The industry has performed a vital function in the search for and the production of new drugs which are medically beneficial. A vast amount of capital is involved in the operations of this industry and for continuing progress profitable returns on investment are necessary. Sales promotion is one means by which this end is achieved and large sums are expended on this complex operation. The basic problem involved is that of getting the promotion message to the right person (the medical practitioner) at the right time and at the right price—in effect to sell.

5.21 The medical practitioner for his part has the well being of his patients to consider and has to be fully informed as to the properties of the drugs he uses. In the words of D. R. Laurence: "The doctor, before treating any patient with drugs should have made up his mind on five points:

1. Whether he should interfere with his patient at all and if so:
2. What alteration in the patient's condition he hopes to achieve.
3. That the drug he intends to use is capable of bringing this about.
4. What other effects the drug may have and whether these may be harmful.
5. Whether the likelihood of benefit and its importance may outweigh the likelihood of damage and its importance." (*Clinical Pharmacology, 1966.*)

The ever-increasing number of new drugs often influences the busy medical practitioner, with too little time or means to make his own evaluation of the efficacy, safety, or merits of the new drug compared with drugs already available, to depend largely on the evidence and recommendations of the promoter. This is particularly true if he has all too few opportunities to consult his colleagues or to attend post graduate courses and seminars. It is imperative, therefore that promotial material should be completely honest.

5.22. In some instances the pharmaceutical industry offers facilities and finance for seminars which are not necessarily product orientated. It contributes in some instances to post-graduate courses and provides travelling fellowships and all these activities have greatly benefited the medical profession and their patients. The committee is of the opinion that these methods of promotion are to be commended and an expansion of these activities could well replace some of the existing methods of promotion.

5.23 The pharmaceutical industry in promoting its products makes considerable use of journal advertising, the employment of representatives known as medical detailers, and of direct mailing. Journal advertising in this country frequently falls short of the more stringent requirements that apply in the United Kingdom and the United States. The United Kingdom Medicines Act 1968 requires that any promotional material must be consistent with the terms of the product licence and this must be preceded or accompanied by a data sheet setting out the essential facts in an objective and standardised way. The Committee on the Safety of Medicines ensures that indications, contra-indications, and possible adverse effects are plainly and concisely brought to the prescribing doctor's notice. Through its Food and Drug Administration the United States has promulgated similar requirements and in 1971 considered a proposal that labels contain information in substantially the following format: description, actions, indications, contra-indications, adverse reactions, dosage, and administration. This proposal would, however, be of limited value in this country. Usually the manufacturer includes a data sheet with original containers of a product but these are rarely seen by the prescribing doctor as the original container is handled by the pharmacist.

5.24. Drug manufacturers and distributors employ representatives who visit doctors, hospitals, and pharmacists, to introduce new products, to give product information when requested and to renew flagging interest in products in general use. These activities are so successful that pharmacists frequently become aware, through changes in the prescribing pattern, that a particular representative has been

in the area. Those representatives who possess a basic scientific background and are well trained in their field may be of considerable value to the medical profession, but this is by no means always the case. When this basic scientific background is lacking it is not possible for medical detailers to fulfil their proper function and they may then only communicate by restating the training given by their promotional industries. An encounter with a representative of this type often makes a medical practitioner reluctant to grant interviews to pharmaceutical representatives, considering it a waste of valuable time of which there is all too little to spare. There have been suggestions, not only from overseas but also in this country, that there is a need to ensure that unbiased basic training in relevant scientific disciplines is available for pharmaceutical representatives. So trained they could supply the useful, factual, and balanced information required by the medical profession rather than the trappings of salesmanship. We agree with Weiss who states: "Time is running out for the ethical drug detailman's old fashioned ways. Few industries have been saddled for so many years with a selling practice of such dubious economic merit and of such enormous cost as the ethical drug industry's detail sales function."

5.25.1 Direct mail advertising takes many forms. The simplest is by the dispatch of circulars, circular letters, and pamphlets. Unless these circulars contain information on a new drug they may be of little informative value, and are mainly intended to remind medical practitioners of a product to ensure a continuing demand. Many manufacturers do provide a useful service by mailing information cards in a format which gives all essential information in a fileable form. It is considered that if manufacturers could agree on a standardised format and card size, a more useful form of direct mail advertising would result.

5.25.2 Much ingenuity is sometimes used to induce a recipient to read direct mail advertising. For example, hand-written letters, telegrams, the use of first-day covers, and letters posted overseas with foreign and unusual stamps. The main beneficiaries of this flood of mail—20–30 a week is not uncommon—are Post Office revenue and philatelists.

5.25.3 In the endeavour to keep a product in mind, scribbling pads, desk calenders, diaries, ballpoint pens, and gadgets of all kinds are provided, each bearing the name of a product. A particularly insidious form of advertising is the provision of preprinted prescription pads for a product which requires only the name and address of the patient, the signature of the prescribing doctor and the date.

5.26 The supply of drug samples to promote the use of new preparations or encourage the use of one manufacturer's product rather than some other is common practice. In spite of the opinion of some that this practice is worth the considerable expense involved such confidence may be misplaced judging by the large quantities of samples sent to hospital pharmacies periodically by some medical practitioners.

5.27 Periodicals of varying standards are published for the dissemination of information concerning therapeutic drugs. One such periodical which presents comprehensive, objective, unbiased, and

up-to-date reviews on old and new drugs is *New Ethicals and Medical Progress,* a monthly publication which is self-supporting through subscriptions and advertising. The editorial content is prepared by its own professionally qualified staff together with some 74 specialist consultants. Authors of review articles are experts in the particular fields and monographs on new drugs are critically reviewed prior to publication by a panel with specialist experience and expertise in therapeutics and pharmacology. This approach seems to offer a source of factual, objective, and authentic information in a form which is useful to medical practitioners.

5.28 From the point of view of the pharmaceutical industry, promotion and advertising are used as tools for selling their products. The medical profession, however, requires reliable, succinct, full, and accurate information on the proper use of therapeutic drugs to enable each medical practitioner to make his own further evaluation. The committee believes that the industry can, by supplying this type of information and by avoiding methods perilously close to the unethical, provide a better service to public health.

5.29 The committee agrees with Dr James Goddard, until recently Commissioner of the United States Food and Drug Administration, who has posed the question—"What is the role of government in a medicated society?" and has answered—"That it should try to maintain such a balance that the safety of the public, the freedom of the doctor and the initiative of the industry are all preserved."

5.30 The committee welcomed the Consumer Council's recommendations on advertising in their annual report to Parliament for the year 1972. However, while in general agreement with the view that, if called upon, advertisers should be able to provide satisfactory evidence to justify any claim made, the committee considers that there will be little to be gained by setting up a body similar to the old Medical Advertisements Board which proved, in practice, to be largely ineffective. In the main, this was because the Medical Advertisements Procedure Rules 1946 (S.R. 1944/47) fundamentally changed the character of the Medical Advertisements Act 1942. While the Act established a substantially administrative tribunal, taking the initiative in requiring claims to be proved and then determining the issue without involving any third party, the rules introduced an adversary system, and rendered the jurisdiction of the Medical Advertisements Board dependent on the receipt of a formal "application" from an "applicant", who, so the rules envisaged, would be locked in combat with the advertiser (the "respondent"), the board having the function of adjudicating between them. As neither the Act nor the rules made any special provision for policing the legislation, the most likely, and in practice the only conceivable, wearer of the mantle of "applicant" was the Department of Health which, as the body servicing the board, the chairman of which was its own permanent head, was placed in a highly equivocal and indeed impossible situation. In addition to this duplicate role, the department had neither the staff nor the facilities to undertake both the task of servicing the tribunal and the task of complying with the virtually inoperable formalities which the rules imposed on "applicants" and the department.

III. EDUCATIONAL ASPECTS OF PRESCRIBING AND USE

5.31 The committee has discussed at length possible ways of improving prescribing patterns. In this connection the committee regards education as a continuous process and recognises that graduation with a degree in medicine and subsequent registration are merely landmarks in this process. It recognises that therapeutic knowledge and habits are largely acquired after qualification. Consequently the committee recommends the development of post-graduate courses with both specialist and general practitioner participation in wider aspects of knowledge about drugs and their administration.

5.32.1 Pharmacology, which is the study of drug structure and action on living tissues, fits into the medical course at several levels. An introduction is given in relation to physiology teaching, which is concerned with the way biological processes work in the normal body and later, when pathology is being studied, is related to the effect of diseases on body structure and function. Fuller understanding comes only when the student has a deeper knowledge and understanding of disease processes as they affect living people and this develops considerably later.

5.32.2 Therapeutics is the term given to the study of the treatments of disease and includes the use of drugs, nursing procedures, physiotherapy, and some aspects of surgery. These subjects are taught in association with the study of medicine and surgery and, usually, by physicians and surgeons who are teaching students dealing with sick patients at this advanced level. Some aspects of therapeutics require a greater involvement from pharmacologists than is currently possible as it is only when the student has a fuller concept of the problems of sick patients that the importance of the pharmacological aspects of how particular drugs act, and their complexities, that the dangers and side effects can be fully understood.

5.32.3 At the medical undergraduate level arrangementts for teaching pharmacology and therapeutics still leave much to be desired. There remains a strong tendency in medical education to emphasise skill in diagnosis at the expense of skill in treatment. The attention of the University authorities and others concerned is drawn to the need to strengthen these disciplines.

5.33 The prescribing of drugs requires such a broad knowledge of medicine that only medical practitioners can be given this responsibility. However, pharmacists play an equally important part in the wider field of drug control. New methods of drug distribution and recording, the introduction of strip and unit packaging, and the presence of pharmacists at ward level have resulted in dramatic drops in medication errors, as recorded both here and overseas, and point the way to safer medication: the right drug given to the right patient in the right dosage at the right time. With the current shortage of registered nurses working in hospitals, pharmacists may be called upon to play an increasing part in the administration of drugs. In view of the increasingly responsible role of hospital pharmacists, the committee notes with approval the development of the 4-year bachelor of pharmacy course at Otago University.

5.34 The committee notes with interest and approval the action of the Council of the Pharmaceutical Society of New Zealand in accept-

ing the necessity of following recommendation 22 of the first report by planning a system of continuing post-graduate education for pharmacists and appointing a committee for this purpose. The committee expresses its approval of the excellent response of pharmacists in general to recommendation Nos. 1, 2, 3, 4, and 7 of the first report. Implementation of recommendation 9 would be welcomed by the profession.

5.35 At the post-graduate level, much more can and indeed should be done. Therapeutics is currently accepted as a part of the post-graduate educational programme of the New Zealand Post-graduate Medical Federation in its courses, but apart from this, the only continuing formal post-graduate education is supplied by the Department of Health in its Clinical Services pamphlets to doctors. These consist of therapeutic notes and newsletters issued regularly throughout the year. Some aspects of work in this respect undertaken by drug companies is also to be commended (Section 5.27.)

5.36 The committee considers that great enlargement of activity is needed here. Not only is the appropriate post-graduate educational need not defined but it appears that no special effort is being made to define it or even to deal more urgently with the problems. The committee recognises that within the Department of Education studies of the type it has in mind are currently being undertaken in relation to education in general. Perhaps a closer liaison between the Departments of Education and Health could be extended in this field.

5.37 It appears to the committee that effort needs to be directed towards the general practitioner specifically. At present some valuable work is being undertaken by the visting practitioners of the Department of Health and such appointments could with advantage be increased. How can the general practitioner be persuaded and find the time and the means to attend courses to refresh himself on changing and advancing therapeutic practice? How can his undergraduate training be supplemented and refreshed so that he can continue to preserve a critical and appraising mind in relation to treatment? This relates so clearly to the core of his work that schemes need to be devised whereby he has an accepted commitment to attend such courses at some flexibly regular intervals.

5.38 The committee is fully aware of the very great interest that a wide range of professional bodies and associations are taking in the whole field of continuing medical education. It recognises the immense amount of time devoted by the Royal Colleges, the colleges, and other professional associations relating to more specialised aspects of medicine, and by the New Zealand Post-graduate Medical Federation which, with a minimum of financial support and an optimum of sustained voluntary effort, has made significant contributions to the needs of post-graduate medical education.

5.39 The committee welcomes, therefore, and commends the initiative that underlies current moves to set up a Council of Post-graduate Medical Education in which all the bodies properly concerned in this field will have representation. The committee likewise welcomes moves to set up trust funds, and to prepare the way for administrative and financial measures that will establish a firm basis for continuing

post-graduate medical education in which the importance of therapeutics and pharmacology may receive their due and proper share of attention.

5.40 Elsewhere in this report the committee has directed attention to the urgent need for a better and more informed understanding, within the community, of the immense potential for good attendant upon the proper use of drugs prescribed with sound judgment and administered in accordance with clear instruction; and the counterbalancing potential for harm when drugs are misused, whether by virtue of neglect or misunderstanding of the prescriber's instructions, or use for purposes and in ways other than those for which they were intended or were appropriate. Reference is made elsewhere in this report, particularly in section 8, to the number of ractors both favourable and adverse to more enlightened and informed understanding within the community and on the part of all involved in the diffusion of information. The committee fully shares the view that much of the information and misinformation currently disseminated errs on the side of overemphasis on the nature of the drug itself, to the neglect of the circumstances, personality and motivations of the user, and the need for discerning wise and prudent controls in their use. Good and effective modern drugs, like fire, are excellent servants and, like fire, they prove themselves to be bad masters, threatening not only the misuser but also many others within the community.

Recommendations

1. That the committee recommends the attention of pharmaceutical manufacturers and promoters to the need to ensure that all promotional material intended for the medical profession be set out in such a way as to ensure that any possible adverse reactions and effects are given sufficient prominence. The material should constitute a balanced report on the properties of the drug for therapeutic purposes. In making this observation the committee recognises that, whilst many firms are meticulous in this regard, others would seem to observe a somewhat lower ethic.

2. That the content of all advertising of therapeutic drugs should be subject to a close and meticulous examination before publication to ensure that claims made are supportable in fact and that advertisements are not silent on any likely adverse effects. It is recognised that, in large measure, the N.Z.B.C. already has a self-imposed code in this respect which is applied to such advertisements, and that this code has gone an appreciable way towards ensuring that only factual and supportable information is transmitted.

3. That the University Councils concerned be urged to provide for the upgrading of undergraduate programmes of pharmacology and therapeutics in New Zealand Medical and Clinical Schools.

4. That the universities, in consultation with the New Zealand Council of Post-graduate Medical Education be urged to assist with the furtherance of post-graduate education facilities, initially in each of the medical and clinical schools and, ultimately, in other appropriate centres.

5. That early attention be given to inaugurating a scheme whereby general practitioners attending approved post-graduate courses, and on study leave, may have their expenses reimbursed in line with those obtaining in certain countries overseas, and whole time hospital medical officers as appropriate could, with advantage, participate in such a scheme.

6. That, with a view to further encouraging maximal participation in continuing post-graduate education for the general practitioner, consideration be given to periodic bonus payments to practitioners who have fulfilled requirements of the Royal College of General Practitioners for continued membership of the college or to some agreed lower level of attendance related thereto.

7. That ways and means of improving existing post-graduate educational opportunities for medical practitioners and pharmacists be given due attention by the respective professional organisations, colleges, and the New Zealand Council of Post-graduate Medical Education, and that the appropriate divisions within the Department of Health participate at some stage in such discussions.

8. That in any revision of legislation relating to the control of drugs with a significant potential for misuse and its eventual incorporation into a single statute, provision should be made in regulations to ensure that there are sufficient powers to control the not uncommon practice of persons seeking a controlled drug from a medical practitioner without declaring that they are already in receipt of supplies from another practitioner.

6. TREATMENT AND MANAGEMENT

6.1 Since our first report the committee has spent much time in study and discussion of the treatment and management of persons involved in drug misuse and especially of those who are or claim to be dependent. We have considered a wealth of material in the form of submissions from persons involved in a variety of ways, including both drug users and medical practitioners, reports from committee members and a medical officer of health who visted treatment centres overseas, numerous articles in professional journals, and several key reports from overseas committees and commissions. We have found the field characterised by uncertainty, wide difference of opinion, conflict, strong and often emotional advocacy of particular solutions, and frequent and rapid changes in the focus of interest for drug users on the one hand and professional workers on the other. These difficulties complicated the committee's deliberations and combined with competing pressures on the members most closely concerned to delay the writing of this section until the others were completed. In the event we feel this has not been a bad thing. Taking all factors into account we have decided that it would be not only unnecessary but also unwise to embark upon a detailed discussion of either the literature or, of possible or preferable, patterns of treatment. The latter in particular cannot be discussed in the abstract but must be developed in the context of practical experience, ongoing debate, and interaction between those directly involved, in response to changing circumstances. In an area of treatment as difficult as this, maximum flexibility and room for manoeuvre must be allowed to both treatment team and patients. Nevertheless, on certain matters of general principle, as distinct from detail, we feel that a fair degree of consensus has emerged both in the work of this committee and in the reports of comparable groups overseas. Accordingly we propose to confine ourselves in this section to a discussion of general principles and to present in an appendix a number of passages from submissions which we consider of sufficient interest to be made available over their authors' names, as a basis for debate. These are not all in agreement on every point, and the committee points out that the views expressed are those of the authors and not necessarily endorsed by the committee.

6.2 To begin with, the committee emphasises that New Zealand must developed its own patterns and facilities for treatment and rehabilitation related/appropriate to the nature and incidence of drug misuse (especially of the opiates) in New Zealand and adjusted to coping with local shifts and trends, which are sometimes behind those overseas, sometimes ahead, and sometimes quite independent. Hitherto not a little harm, much wasted effort, and some misleading publicity have accompanied excessive zeal to copy or borrow methods appropriate in a different setting. At the same time, New Zealand workers in this field can learn a great deal from overseas experience and should keep in close touch with new developments elsewhere. Apart from regular reading, professional workers should be actively encouraged by the Department of Health and other employing agencies to establish and maintain personal contact with their counterparts in overseas institutions, especially in situations similar to those in New Zealand. It would be most helpful if at least one worker in the field could be sent

overseas each year preferably to work in one or two particular centres for several months. The benefits of such firsthand contact could be doubled if an exchange of workers could be effected. In addition we would warmly recommend those looking for a fuller discussion of both principles and methods to make a close study (making allowances for differences in setting) of the Treatment report of the Canadian (Le Dain) Commission of Enquiry into the Non-medical Use of Drugs, and of its counterpart in the report of the National Commission on Marihuana and Drug Abuse entitled *Drug Use in America: Problem in Perspective*. Readers should constantly bear in mind the vastly different scale of drug abuse in North America compared with its fortunately minor scale in New Zealand as at present.

6.3 As one of the contributors to appendix XIII remarks, the treatment of drug dependency, like treatment in any area where success rates are low, has generated at one and the same time a multiplicity of cures and an impassioned advocacy of single and exclusive approaches. The situation reminds us of the old fable about the traveller who found many people assidously searching in the desert for tiny scraps of papyrus, watched by a bystander smiling silently to himself. Asked the reason for his amusement, the bystander replied: "Don't you know? Truth has been torn up and scattered over the desert, and each one of these people you see who picks up a tiny fragment will be forever persuaded that he alone has found the whole truth." The committee insists that, just as drug dependency and drug misuse constitute not a single problem but a range of problems that are combined in varying constellations in particular cases, so there is no single answer or approach, no universal remedy, but a clear need for diversity and flexibility in treatment patterns, evidenced in the offering of a variety of methods in differing combinations and organisational settings. This diversity and flexibility must, however, be achieved in combination with the ability to resist manipulation in the patients' own best interests.

6.4 In both public and professional discussion there is a tendency to focus interest on opiate dependency and the illegal use of drugs. The proportion of those properly assessed or otherwise established as truly dependent on opiates is very small indeed, whether compared with the numbers in overseas countries as for example, Canada, Britain, or the United States, or with the number of those dependent on alcohol in New Zealand. This was true even in 1971 and 1972 when several hundred young people, most of whom were not initially dependent, were obtaining opiates on legal prescription from doctors whom they had persuaded of their need for this treatment for dependency. It is important to remember, however, that the problem is *not* confined to those who are dependent on opiates nor to those involved in illegal use: help is also needed and must be provided for those who are dependent on other than opiates, for those engaged in multiple drug use who are dependent on a total pattern of drug misuse rather than on any particular drug, and those whose dependence originated in and/or was developed while under medical supervision.

6.5 The aim of any treatment programme for drug misusers must be their rehabilitation as independent members of the ordinary community. Its success will depend substantially on the extent to which

its clients are helped to retain, or perhaps to develop for the first time, their own healthy social identity. There are powerful economic reasons for avoiding institutional or hospital treatment programmes whenever possible because of their very high cost. Fortunately there are equally strong therapeutic reasons for moving drug treatment programmes no further away from the ordinary community than is demonstrably necessary for the welfare of the individual client or, in a small proportion of cases, of other people. While some residential programmes will be needed the emphasis should be on providing services which can help the drug misuser before his problem reaches the stage at which he cannot be assisted outside them. If he does require residential or hospital care for a period those responsible for his treatment should remember that his drug difficulties will inevitably be compounded by additional social difficulties when he is discharged and has to learn how to cope with ordinary life.

6.6 For this reason treatment programmes must aim to offer help at the earliest possible stage. This can only be done if full use is made of existing community health and welfare services, both state and voluntary, to provide a close network of facilities to which a person with a drug difficulty, or those concerned for him, can turn for correct information, and helpful advice. Family doctors provide one of the key services at this local community level, but they must be complemented by existing state and voluntary health and welfare services able to act as the first contact for persons needing help and to advise on the specialist services available to assist them if necessary.

6.7 It is also most desirable that, within the resources available in a small country, New Zealand should develop as wide a range of specialist services as may be appropriate based on the knowledge of all the related professions and the interest of concerned laymen, and should encourage both innovatory projects and thorough evaluation of all aspects of its treatment programme.

Assessment and Treatment Centres

6.8 However, the committee recognises the difficulties of dealing with persons who are known or claim to be fully dependent on drugs, especially when a pattern of illegal use and/or the use of opiates is involved. Management of such cases requires specialist knowledge drawn from several disciplines and, above all, experience. Their problems are as much social and psychological as strictly medical. As patients they are often as knowledgeable as the doctor (or think they are) and are strongly motivated to press him into prescribing a legal supply of opiates at as high a level as possible. For these reasons it is important that each case should be fully and properly assessed before being placed on any course of treatment, let alone one that involves continuing prescription of opiates; that the prescriber should have access to the advice and support of colleagues who also have close contact with the client; and that expert advice should be available to the client to help him cope with the non-medical aspects of his problem. The average general practitioner has little chance of acquiring the necessary experience, and even the doctor who builds up experience through a particular concern for individuals

involved in drug misuse is unable to provide the range of services they need or to resist their pressures, as long as he is in general practice without ready access to colleagues who can check and support him in his judgment of a case.

6.9 In the most serious cases of drug dependency or misuse, treatment will involve at least a period of hospitalisation involving treatment that is primarily a medical matter. But such cases are comparatively few in number, and lengthy hospitalisation is neither helpful nor necessary in many others. To meet the needs of this latter group, the committee approves the provision of special treatment centres in at least the main New Zealand cities with *official approval and support*. Such centres should be equipped with the necessary physical facilities (or access thereto) and specialised staff to undertake firstly the assessment of those who claim to have a problem of drug dependency, and secondly the continuing management on an outpatient basis of those whose recommended treatment regime includes administration of an opiate. We do *not* intend that the treatment of all drug dependent cases outside hospital should be strictly confined to such centres. We anticipate that clients assessed and/or treated initially at such centres might appropriately be transferred to a general practitioner or some other agency for supervision, for example, where a client has completed withdrawal from the drug of dependency, where a client is well established on a maintenance regime and has given evidence of responsibility in adhering to it, or where a client normally lives outside or in a remote part of the city. However, we would suggest that any decision to handle such cases outside the treatment centre should be made on the basis of consultation between the prescribing doctor and members of the centre staff and with the approval of the medical officer of health. (For a more detailed discussion of the management of persons dependent on opiates in and out of hospital see appendix XIII.)

6.10 We would reiterate that the establishment of centres of this type in the main New Zealand cities should be carried out with official approval and support. For one thing they should be included among the facilities which the State should provide for the benefit of its citizens as part of medical care. For another they need to be able to call on the health services to supply what they lack in the way of laboratory, medical, psychological, and social worker skills. Centres of this kind could be set up entirely within the health services themselves, for example, as clinics attached to hospitals or under separate control but linked to the health services on an official basis as occurs in the case of the NSADD clinic in Wellington. Because those involved in drug misuse are commonly wary of services identified as "establishment" there is a good deal to be said for such centres having a degree of independence from the state healtth services, and receiving their funds indirectly rather than directly. Once established, however, it is their reputation for understanding and successful treatment which will attract or repel, rather than the form of control. Such centres should also have close liaison with approved voluntary agencies and organisations working in the same field through whom cases can be referred.

6.11 Whether these centres limit their functions entirely to assessment and the management of opiate dependent cases, or widen them

to provide assistance for other drug problems including those related to alcohol, should be a policy matter to be decided by the administration and staff in the light of particular local circumstances. There are obvious difficulties and dangers in treating dependent persons and others less-heavily involved in drug misuse in the same clinic, but they are not insurmountable and are offset by some advantages. The committee considers that the staff of special treatment centres would gain considerably from regular contact with persons on the fringe of or outside the dependency group. This could be done through liaison between the centres and other organisations engaged in helping drug misusers. It would help them to keep their own work in healthy perspective as a key part, but only part, of the community's total treatment programme for drug misusers, and make them aware of changes in the total pattern of drug misuse which could affect their own work at the centre.

6.12 In the case of those dependent on opiates, the committee stresses the need for treatment to include attention to personal and social as well as obviously medical problems. Preparation for rehabilitation should be an integral part of the treatment programme right from the beginning. To this end, the staff of treatment centres should include a diversity of skills and be prepared to work very much as a team. In our opinion psychologists and social workers have a vital role to play in the operation of such centres, not only dealing directly with clients but also sharing with the doctors in assessment of and decision-making about cases and supporting the doctors in their difficult role as prescribers. Part-time workers or voluntary assistants with expertise in finding employment and teaching occupational and leisure-time skills might also profitably be added to the team, although help might well be sought from the rehabilitative services for the disabled now being provided by the state and voluntary agencies in combination.

6.13 The committee would also emphasise the importance of the director and staff of these centres being sensitive and responsive to the outlook and susceptibilities of clients and willing to organise their programme to meet their expressed and unexpressed needs. They should provide at least on-call service at weekends and operate over sensibly extended hours during the week to accommodate those who are in full or part-time employment. They will also probably have to be prepared to relax if not wholly abandon formality in layout and furnishing of premises; dress and personal interaction; to move out from the centre as a physical place to meet clients in their own setting; and to take an interest in their lives and personalities on a comparatively wide basis. We recognise that in some respects this will increase the risk of attempted manipulation, but we believe that the best insurance against this is the team approach mentioned above and the building up of many-sided relations between staff and clients.

6.14 The committee recognises that some persons who have overcome their dependence may have a contribution to offer to the management of those who are still involved. The utilisation of the potential influence for good of the ex-addict calls for fine judgment and discrimination, and on balance it would seem to be preferable that such experience should be used in the context of the treatment team at a special centre.

6.15 Those centres which undertake medical aspects of treatment and especially the prescription of drugs must ensure that where a patient is referred to a private practitioner or to another centre, such referral is *invariably* in the form of *written* advice and directions to the medical practitioner as to the prescription and instructions that have been given to the patient. The practitioner or centre to whom the referral is made should for their part act only on *written* instructions addressed to them directly and then only after satisfying themselves beyond reasonable doubt as to the identity of the person presenting. Verbal assertions on the part of a patient should always be checked.

6.16 The committee recognises that there is a need for frequent consultation between the heads of centres set up within or officially linked with the health services, firstly in order to establish a uniformity of procedure for the referral of patients that is in keeping with any regulations currently in force, and secondly in order to share their experience and lessons learnt. In both regards the Department of Health, through its medical officers of health and Clinical Services Division, clearly has a co-ordinative and advisory role to play. As indicated above, we would recommend that the Department of Health also assist the professional workers involved to maintain contact with workers in the same field overseas.

The Prescription of Opiates as Part of Treatment

6.17 The committee accepts the prescription of an opiate as part of a course of treatment for opiate dependency in certain cases. Experience here and overseas has demonstrated that, where such dependence is highly developed and consequently embedded in a life pattern centred around opiate use, to insist on short-term withdrawal followed by abstinence is unkind, unrealistic, and subject to failure. Dependence on a opiate includes a strong psychological as well as physical component and its diminishment requires a plentiful supply of time, patience, and understanding, and the development of the patient's motivation towards abstinence. However, the committee is unanimously of the opinion that the decision to place any person on a course of prescribed narcotics is a very serious matter and should only be undertaken after careful assessment has established an advanced degree of dependence and the unlikelihood of other approaches succeeding. (Refer to the Metge views in appendix XIII.) We recommend as a matter of urgency that professional workers with experience of such treatment should confer with a view to laying down some clear guidelines about the kind of cases for which continuing prescription of an opiate is appropriate.

6.18 While accepting that some patients may need to be maintained in this way for at least one and even several years, the committee would insist that the long-term aim of such treatment programmes should be complete withdrawal from opiate use and establishment in a satisfactory way of life that excludes the misuse of drugs. It may be that a few patients never achieve this long-term aim, but we believe it would be a mistake to label any person as being on permanent maintenance. There is a considerable body of evidence which suggests that opiate users who survive past a certain age do ultimately reach a stage where they are able and willing to achieve a drug free life, especially if they have developed stable personal and work relations.

6.19 The committee also endorses the decision, given effect by Amendment No. 4 to the Narcotics Regulations 1966 made in May 1973, to restrict the right to prescribe narcotics for the treatment of drug dependency to a limited number of doctors with special knowledge and experience, even though this involves some limitation upon the rights of both doctors and patients. Where, as in this case, there is a threat to the life and health of individuals and indirectly to the well-being of the community, we believe that sensible controls are justified. (Refer Drugs and the Law, section 4.) They should, however, be applied in a humane and flexible way. Strong support for the principle and wisdom of restriction of the right to prescribe opiates for drug dependency has been expressed within the last year or two by each of the outstanding overseas reports on the subject, notably the Treatment report of the Canadian Commission of Enquiry into the Non-medical Use of Drugs (pp. 20–21), and the Treatment and Rehabilitation sections (pp. 301–332 and 342–345) of the second report of the United States National Commission on Marihuana and Drug Abuse entitled *Drug Use in America: Problem in Perspective* (1973).

6.20.1 On the basis of our studies and reports from committee members who had travelled overseas, the committee drew the attention of the Department of Health to the fact that Canada and the United Kingdom (and shortly afterwards the United States) found it necessary to pass legislation limiting the right of doctors to prescribe opiates to opiate dependent persons. This was a direct response to a rapid increase in the incidence of opiate dependency arising from the prescription of opiates in doctors' practise rooms, where even the minimal needs for assessment, management, and control are virtually unattainable. The committee drew the attention of the Department of Health to the likelihood of a similar increase in the incidence in New Zealand, particularly with regard to an escalation in the use of methadone in inappropriate conditions. The committee further pointed out that the Federal Government of Canada gave even higher priority to the control of methadone than it did to the control of amphetamines and both were controlled by the latter end of 1971.

6.20.2 In the event, a similar situation did develop in New Zealand, with a rapid increase in 1971 and 1972 in the number of persons successfully representing themselves to doctors as drug dependent, and especially dependent on opiates, until the number receiving opiates on prescription ran into an estimated 500–600, at least two-thirds, if not more, of whom were not initially dependent at all. It is most doubtful if 2 percent had any significant long-term opiate dependence. However, as we also pointed out to the Department of Health, restriction of the right of doctors to prescribe opiates for drug dependency should not be undertaken until adequate facilities were available to deal with transient emergency situations in the patients likely to be affected as a result. The regulations controlling the prescription of narcotics were not amended until there were such clinics in operation in Auckland, Wellington, and Christchurch, and provision made for treatment in areas such as Tauranga, Hamilton, Napier, New Plymouth, Palmerston North, Nelson, Greymouth, Timaru, Dunedin, and Invercargill.

6.21 Granted that the prescription of opiates has a place in the treatment of drug dependency, the question then arises as to which

particular opiate should be used. The law of the United Kingdom allows doctors at drug clinics to prescribe morphine, but in practice in recent years they have prescribed an increasing proportion of methadone, which is the drug favoured for this purpose in North America. We do not propose to discuss this issue here, on the grounds that this is a decision of detail which is best made by the medical profession in the light of up-to-date medical and pharmacological knowledge. We would, however, express ourselves as entirely opposed to any proposal to use morphine in this context. We would also observe that the enthusiastic early claims made for methadone as a treatment method have not been borne out. It has proved to be as dependency producing as some other opiates and not without undesirable side effects. It may well be that an alternative will come into favour in the near future.

6.22 Finally, the committee would reiterate its view that all controls on narcotics as on other drugs should be subject to regular review, a point already made in section 5.9.

Other Services

6.23 As well as the officially supported assessment and treatment centres which we have discussed there will be a continued need to develop other complementary treatment services which can tap local resources, meet local needs, and try out new approaches, particularly in community-based assistance programmes. Some overseas services of this kind are described in appendix XIII.

6.24 The committee believes it is important that approved voluntary services for which need is established should receive adequate official support provided they meet accepted basic codes of good medical and social work practice. It appreciates the work now undertaken by organisations such as the National Society on Alcoholism and Drug Dependence and the interest being shown in this field by the Salvation Army. It welcomes the official financial support, whether directly by Government grants or indirectly through hospital boards, which is now provided for such organisations, and would like to see this support extended to other agencies which meet the necessary professional standards and are prepared to enter into full and close co-operation with those responsible for the direction of treatment and rehabilitation facilities operated by hospital boards and other health services funded from Vote: Health. This applies particularly to any facility directly involved with the treatment of dependency and, to a somewhat lesser extent, those primarily concerned with counselling.

Liaison and Evaluation

6.25 If the programme sketched out above is to be effective its component sections must plan and work together to serve their particular area of the country. The committee believes that the Department of Health should be given a continuing responsibility for convening regular meetings of the organisations involved in the prevention and alleviation of drug misuse on a district basis. These meetings would provide the forum for information sharing, planning, and evaluation essential if the best return is to be obtained from the available resources.

6.26 There will be an equally important need for adequate evaluation of drug treatment programmes on a national basis. Unless strong and continued emphasis is placed on this aspect of the programme it will not be as responsive as it should be to changing needs, nor will its strength and weakness be identified. In the concluding section of its report the committee proposes that the Government establish continuing machinery for co-ordinating the work of the Government departments, social agencies, and professional bodies which have responsibilities in the wide field of drug use and misuse. An organisation established for this purpose could usefully accept a responsibility for ensuring that the necessary evaluation of programmes is implemented.

Recommendations

1. That the level of financial support for the work of approved organisations such as the National Society on Alcoholism and Drug Dependence and the Salvation Army, in the field of drug misuse, be continued and augmented, subject to the ascertainment of need for particular projects.

2. That all such financial support be contingent upon the development and maintenance of patterns of liaison and full consultation and co-operation with health services and other approved and recognised agencies working in the same field.

3. The committee also recommends, both to the various organisations concerned and to hospital boards responsible for drug treatment facilities, that there should be closer co-ordination and consultation with the Department of Health in the interests of a better public understanding. This is particularly the case with public pronouncement for which widespread publicity may be accorded or sought.

4. That provision be made for at least one worker in the whole field of drug dependency and misuse to travel overseas each year to work in particular treatment centres, preferably on a exchange basis.

5. That the Department of Health should accept a continuing responsibility to:

(a) Foster and maintain consultation and liaison between the state and voluntary agencies involved in drug treatment programmes in each district;

(b) Maintain liaison with and between the staff of assessment and treatment centres on matters such as the criteria for determining those persons for whom opiates should be prescribed for the treatment of dependency.

6. That provision be made for full and continuing evaluation of drug treatment programmes.

7. CANNABIS

I. RECENT DEVELOPMENTS

7.1 Until recently pharmacologists called upon to describe the effects of marijuana and other cannabis preparations found themselves in a predicament. They had to acknowledge that the cannabis plant has been used for thousands of years as a source of intoxicant preparations, that the number of contemporary users probably exceeded 200 million, and that upwards of 2,000 articles had been written about cannabis. Yet there was a remarkable lack of hard facts. Little could be asserted with confidence about some of the most important properties of cannabis preparations.

7.2 The 1967 President's Commission on Law Enforcement and the Administration of Justice wrote: "no careful and detailed analysis of the American experience seems to have been attempted. Basic research has been almost nonexistent." Weil, Zinberg, and Nelson said in 1968 when describing their own clinical studies that they knew of only three other studies on human subjects performed by Americans and they pointed out how all three studies suffered from such defects as lack of controls and lack of specification of doses and quality of marijuana.

7.3 Section 73 of the report on cannabis by the (British) Advisory Committee on Drug Dependence—now commonly called the Wootton report—contains the following statements: "It will be clear from this report that there is still a great deal that we do not know about cannabis. Precise description of the chemical structure and behavioural effects of its active constituents has not yet proceeded far. Chemical research on the synthesis of the active principles of cannabis and some of their derivatives has only recently begun to yield results. Accurate scientific knowledge is lacking of the personality of those who habitually use cannabis, of the significance of the circumstances in which it is used, and of the psychological, physiological and social consequences of its long-term use."

7.4 Suppose that ethyl alcohol had not been isolated as yet and that popular knowledge about alcohol stemmed from observations made for the most part by persons who had broken the law to try such drinks as ginger beer, hokonui, jungle juice, and methylated spirits. In these circumstances one would probably get highly conflicting views about the good and had effects of alcohol. Persons who had tried nothing stronger than near-beer might wonder what all the fuss was about. On the other hand, those who had seen a "skid row" would have reason to consider alcohol a dangerous drug. The police would probably observe quite correctly that men who indulged in sly grogging were far more likely to engage in other nefarious activities than those who did not. This would correspond roughly to what was popularly believed about cannabis in the late 1960s.

7.5 While some of the problems facing persons who wished to study cannabis were chemical ones, others were pharmacological and medico-legal. Thus there was until recently an unwillingness to experiment with a substance not employed therapeutically and having an unpleasant

notoriety. In some countries it was unlawful to perform experiments with cannabis on human subjects, even though experiments on animals might be permitted.

7.6 Widespread recognition of these difficulties, together with the realisation that the marijuana issue had become sufficiently important to justify large-scale research has led to major developments within a very brief period. Probably more good investigations have been carried out during the last 5 years than during the previous 5,000. It should be added, however, in fairness to earlier investigators, that recent progress is largely the fruit of persistent endeavours which led eventually to such break-throughs as the isolation and synthesis of delta-9-tetrahydrocannabinol. When this compound, which is thought to be the chief psycho-active constituent of cannabis, became available to numerous investigators—mainly through the agency of the World Health Organisation—it became possible to make observations with standardised authentic material.

7.7 Research on cannabis can be split into two broad categories. Whereas some studies are concerned primarily with the persons who take cannabis, others are concerned primarily with the drug itself. It is not of crucial importance for psycho-social studies that the cannabis preparations taken should be well-defined materials. On the other hand, pharmacological studies carry little weight unless made with authentic specimens of known potency. As the Canadian Commission of Inquiry into the Non-medical Use of Drugs stated in 1970: "Meaningful research cannot be done on cannabis effects until we agree on a standardized substance and dose ranges . . ."

Recent Publications

7.8 These are of several types. Literally hundreds of papers containing original observations on cannabis have been published in scientific journals over the last few years. Numerous review articles have been published recently. Examples are those of Bromberg (1968), Chesher (1971), Chopra (1969), Grinspoon (1969), Hollister (1971), Joyce and Curry (1970), McGlothlin and West (1968), Medlicott (1971), Pillard (1970), Schofield (1971), and Solomon (1969). The papers presented at a symposium on cannabis attended by a number of American authorities on the subject were published in the December 1971 number of *Pharmacological Reviews.* Papers given at another recent symposium were published in the 1971 number of *Acta Suedica Pharmacologica.* There is not much divergence of opinion in these articles. As might be expected, the more optimistic views concerning possible long-term adverse effects come from those authors whose basic interests are in the psychiatric as distinct from the pharmacological field.

7.9 The conclusions of certain national committees are of particular interest because of the time and expertise they have had available. The description of cannabis now to be given is based largely on material contained in the following reports:

Marihuana: A Signal of Misunderstanding. First report of the National Commission on Marihuana and Drug Abuse. Washington, 1972.

Marihuana and Health. First annual report to Congress from the Secretary of Health, Education, and Welfare. Washington, 1971.
Marihuana and Health. Second annual report to Congress from the Secretary of Health, Education, and Welfare. Washington, 1972.
Cannabis. A report of the Commission of Inquiry into the Non-medical Use of Drugs. Ottawa, 1972.
The Use of Cannabis. Report of a WHO scientific group. World Health Organisation. Geneva, 1971.

Properties of Cannabis

7.10.1 *Nomenclature*—As explained in our first report, several intoxicant preparations are obtained from the Indian hemp plant, *Cannabis sativa.* Marijuana is one of these. It is a mixture of the flowers and leaves dried for smoking. Hashish is the resin obtained from the flowering tops. Unlike marijuana, hashish is normally taken by mouth. Cannabis plant includes all such preparations.

7.10.2 *Botany*—Although only one species of the Indian hemp plant is recognised, certain strains of this are much more potent than others. Marijuana with a high THC content can be prepared from plants grown in New Zealand provided that a suitable strain is used. The potency of cannabis preparations depends also on what parts of the plant are used to make them. The resin contains the highest proportion of active constituents; the flowers and leaves are less active; the stems, roots, and seeds are almost devoid of activity. Contrary to a widespread notion, the male flowering tops are not much less potent than the female ones. Rapid deterioration of cannabis preparations is likely under poor storage conditions.

7.10.3 *Chemistry*—Many chemicals have been isolated from cannabis preparations, including a number of cannabinols. Although several possess considerable pharmacological activity, most investigators have concluded that the distinctive effects of cannabis preparations are due largely to the presence of delta-9-tetrahydrocannabinol (THC). The response to a cannabis preparation of known THC content can be nearly matched by giving a human subject the same amount of synthetic THC. In the body some THC undergoes slight chemical change. At least part of the pharmacological activity attributed to THC may be that of the 11-hydroxy derivative into which it is metabolised.

7.10.4 *Standardisation*—This remains difficult even for analysts with very well equipped laboratories. When samples of the one specimen of marijuana have been sent to different analysts, their estimates of its THC content have sometimes differed by more than 100 percent. Any method based on the determination by chemical means of the THC content of a specimen is open to the objection that other chemicals present may play a part in determining activity. Although biological assays are sometimes employed, they are semi-quantitative at best, and most of them are not very sensitive. Even with some recent experiments on man, it is possible that the dose given differed substantially from that specified. Gross deterioration of the marijuana known to have occurred in one series of experiments, has made it all the more difficult to compare the results of different studies performed with ordinary cannabis preparations. As yet the task of estimating

THC and related substances in such media as blood and urine cannot be performed with ordinary laboratory facilities. A chemical test comparable to the "breathalyser" test for alcohol is unlikely to be developed in the near future.

7.11 *Acute Effects*—Since it is relatively easy to investigate the short-term effects of cannabis on man, it is to be expected that recent work has clarified rather than confuted earlier findings. The descriptions of intoxication with cannabis found in certain textbooks written more than 50 years ago need little alteration except that they can be made more precise. For example, we now have a rough measure of the potency of cannabis preparations in their THC content. To get a mild euphoria, the average adult needs about 3 mg of THC if it is smoked in the form of marijuana but about 8 mg if it is taken by mouth. To become hallucinated, most individuals would need to take four to six times this dosage. An important advantage of taking cannabis in the form of a marijuana "reefer" is that the experienced smoker can gauge the effect being produced and stop at a pleasurable "high". Nevertheless, predicting individual reactions remains difficult, since these depend not only on dosage and route of administration but also on the social setting and on the personality and expectations of the user. Though unusual, severe adverse psychological reactions can occur, especially with naive subjects. Even regular cannabis users are likely to experience some undesirable side effects of the drug from time to time, for instance, sluggishness (the feeling of being "stoned"), nausea, blurred vision, dizziness, incoordination, irritability, anxiety, disorientation, and panic ("freaking out").

7.12 Surprisingly few physiological changes accompany those in mood and perception. The most consistent change in body function is an increased heart rate. In a recent "double blind" study carried out in New Zealand, the observers soon found it desirable not to take each subject's pulse because this was so likely to reveal whether he had been smoking a genuine reefer or a dummy. Even gross over-dosage has little effect on most body functions. Death attributable to physical effects of cannabis is almost unknown.

7.13 The mental changes produced by cannabis are far more important. They have proved difficult to analyse. The impression that cannabis interferes with recent memory has been confirmed by laboratory investigation. This action may help explain why perception of the environment is altered—usually, but not always, in a delightful manner. Changes in the perception of time, which may seem to slow or even stop, might be the basis for the cannabis taker finding himself in a world where there are subtle changes in what he sees and hears and enhancement of such non-dominant senses as touch, taste, and smell. It is understandable that cannabis is reputed to enhance the enjoyment of sexual intercourse; also that one's reaction to state of altered perception depends partly on familiarity with it—the risk of panic is much greater for the neophyte than for the habitué.

7.14.1 Naturally great interest is being taken in whether these mental changes can lead to a deterioration in the performance of various tasks, particularly automobile driving. Numerous well-controlled studies, including two recently performed in New Zealand, have shown that there is deterioration provided that the task is complex and demanding. The

greater the dose of cannabis, the more is performance impaired. Direct evidence that taking cannabis impairs ability to drive a motorcar has been difficult to obtain for such reasons as inability to show by chemical or pharmacological means that a person has taken cannabis. Accident statistics cannot be used without making highly questionable assumptions. Present expert opinion (March 1972) is reflected in the following statement from the Shafer report: "Recent research has not yet proven that marihuana use significantly impairs driving ability or performance. The Commission believes, nonetheless, that driving while under the influence of any psycho-active drug is a serious risk to public safety; the acute effects of marihuana intoxication, spatial and time distortion and slowed reflexes may impair driving performance. That the risk of injury may be greater for alcohol than for marihuana matters little." (Page 79.)

7.14.2 One of the chief objects of research on cannabis at Otago University has been to see if smoking marijuana is likely to impair driving skills. Papers by Dr David Marks and Miss Sally Casswell have been published in *Nature* (241 : 60–61, 1973), and *Science* (179 : 803–805, 1973).

7.14.3 Three types or cigarettes were prepared and standardised by Mr Don Ferry of the MRC Toxicology Unit. All contained at least some marijuana which had had its delta-9-THC removed by extraction with hexane but which closely resembled the active leaf in taste and smell. The dummy cigarettes contained only this material. The others contained enough active material sandwiched between the extracted leaf to provide either 3.3 or 6.6 mg of delta-9-THC. Each experiment was "double blind" in that neither observer nor subject knew what type of cigarette had been provided. All three types of cigarette were tested on each subject, the tests being approximately a week apart.

7.14.4 Since driving a motorcar is a task in which one must carry out a form of tracking while seeking and recognising environmental signals, the subjects were given a "divided attention" task some 30–40 minutes after the cigarette had been smoked. Their performance of this task was found to be impaired if they had smoked a cigarette containing delta-9-THC. The decrement was dose-related and similar to that found after intoxication with alcohol.

7.14.5 One finding which runs counter to a widely held impression was that no significant difference in performance at any of the three cognitive tasks employed or in reported subjective effects was found between those of the subjects who had not taken cannabis previously and those of a matching group who had histories of smoking cannabis socially. While some of the "users" were taking cannabis socially only about once a month, others were taking it as frequently as three times a week. All had been smoking cannabis for at least 18 months, the median period of experience being 3 years. It is of interest that after smoking the placebo material "the experienced subjects reported a greater effect on the variables of visual imagery, auditory imagery, and thought processes, than the naive subjects, presumably reflecting the importance of past learning experiences on the induction of cannabis effects".

7.15 As regards liability to precipitate acute psychotic episodes, it has become clear that this risk is slight, at any rate for mentally well-adjusted persons. The once widespread belief that cannabis users

are liable to commit violent or aggressive acts has not been supported by careful studies of various types; the users are indeed more apt to act "cool" than tough.

7.16 *Long-term Effects*—Sociological studies carried out in various parts of the world have confirmed that the majority of cannabis users take the drug occasionally rather than daily. This had been noticed back in 1894 by the Indian Hemp Commission. It follows from such observations that only a small minority of those who have taken cannabis develop a strong psychological dependence on it. Physical dependence has not been clearly demonstrated in man or in animals; it is exceptional for heavy users to develop significant withdrawal symptoms. Although it remains debatable whether tolerance occurs, it can at least be stated that tolerance does not occur to an important extent.

7.17 The risk of organ injury appears slight even with moderate use (such as smoking marijuana several times weekly, but no more than once daily, over a long period). Heavier use may lead to chronic diminution of pulmonary function. However, there is little that can be asserted with any confidence about the long-term physical toxicity of cannabis. The WHO scientific group mentioned earlier, therefore, recommends prospective studies with suitable control samples of non-users. Among the possible long-term effects which they would like to see studied are "the occurrence of bronchopulmonary and cardio-vascular diseases, chromosomal abnormalities, teratogenic effects, organic brain damage, deficits in cognitive and other skills, and social effects such as crime and other deviant behaviour". Presumably the WHO committee has taken stock of a number of observations which make one hesitate to claim that long-term effects are probably of minor importance.

7.18 Some disquieting laboratory and clinical findings have been published during the last year or two, i.e., since preparation of both the Le Dain and Shafer reports. (Abnormalities of Mitosis, DNA Metabolism and Growth in Human Lung Cultures Exposed to Smoke from Marijuana Cigarettes and their Similarity with Alterations Evoked by Tobacco Cigarette Smoke by Cecile Leuchtenberger and Rudolph Leuchtenberger.)

7.19 The risk of cannabis producing adverse psychic effects is also proving difficult to assess. Many observers are prepared to accept that the incidence of psychiatric disorders amongst regular cannabis users is greater than would be expected by chance. However, a greater incidence can be explained in various ways. Thus as the Canadian Commission has pointed out: "Pathological persons may be more likely to use cannabis (or to use it heavily)—especially when use is statistically unusual or deviant. This might, for example, represent acting out or rebellious behaviour, attempted self-treatment, poor judgment, or an inability to find pleasure by other means." In a wide range of cultures excessive use is associated with personality inadequacies. Of particular interest is the relationship of an "amotivational syndrome" to heavy cannabis use. Would those who develop this lethargic state, characterised by a loss of interest in conventional goals, have fallen victim to it because of inherent personality defects even if they had not been taking cannabis? We cannot say, for lack of relevant infor-

mation. It therefore remains possible that even heavy use of cannabis does not harm the maturation process in adolescents; but to assume this in framing a national policy would be to take a major risk.

7.20 The belief that cannabis users inevitably progress to "hard" drugs like heroin has been so thoroughly exploded that one is apt to ignore any association between the use of cannabis and that of other drugs. Actually, persons who take cannabis are more likely than non-users to have tried other psycho-active drugs (including alcohol and tobacco). This is probably due in large part to peer pressure. As stated in *Marihuana and Health* (II, p. 48): "Heavy marihuana use apparently tends to involve the user in a drug-oriented group or subculture which may alter his life style and his conception of himself. It may also increase his opportunity to try other drugs, including opiates . . . There apparently is an individual "drug proneness" factor that accounts in part for the phenomena of progression, substitution, and multiple drug use." Judging from preliminary results, studies now being carried out in New Zealand will confirm that regular cannabis users are more likely than non-users to experiment with other psycho-active drugs. The key fact, however, is that the great majority of those who have tried cannabis do not progress to hard drugs. They either remain with marijuana or forsake its use in favour of alcohol. Only moderate and heavy use of marijuana is significantly associated with the persistent use of other drugs.

II. TOWARDS FORMULATING A POLICY

7.21 Members of the committee have frequently been asked whether they can reconcile their views on marijuana and other cannabis preparations with those on alcohol and tobacco. This is fair comment. Drug control measures should not flout broad concepts of law or science. For the very reason that the problems arising out of the use of alcohol and tobacco have become well known, we think it desirable to evaluate cannabis alongside these other drugs, especially in the light of findings discussed in the preceding section.

Drug Control Measures

7.22 There is a widespread impression that legislation to restrict the use of drugs stems from a dislike of hedonism. However, the history of legislation on drugs shows that most regulations are belated attempts to deal with obviously harmful practices. For example, alcoholism has existed from time immemorial. Bad as the situation is today, it was even worse in Western countries during the last century or two. When distilled alcoholic drinks like gin and whisky became widely available, the abuse of alcohol reached epidemic proportions. Thus to many victims of the Industrial Revolution the gin palace offered the consolation of "Drunk for a penny, dead drunk for twopence". Yet little was done in the legislative field until quite recently. In Great Britain, sweeping changes were not made until late in World War I, when it was acknowledged by Lloyd George that the flow of munitions to the front was being impeded even more by drunkenness among factory workers than by German submarines. Today the cost in road accidents of even mild drunkenness is forcing the public to accept increasingly tough regulations.

7.23 And so it has been with most of the other drugs which are liable to be abused. When de Quincey wrote his "Autobiography and Confessions of an Opium Eater", there were no laws to control the non-medical use of opium. The Chinese were well ahead of Europeans in recognising the danger of abuse, as we should remember with shame in recalling the so-called "Opium War" of 1839–42 (the ostensible cause of which was the refusal of the Chinese Government to permit the further entry into their country of opium from India). When heroin was introduced in 1898, it was thought to be non-addicting. Like cocaine, which had been introduced just a few years earlier, heroin was even advocated as a cure for morphine addiction. More recently the risks associated with taking such drugs as pethidine, lysergic acid diethylamide (LSD), and the amphetamines were initially underestimated.

7.24 What are these risks? Are they essentially those arising out of the development of physical dependence, which may drive the user to criminal acts if he is to maintain a supply of the drug? Clearly not, since physical dependence is not produced by cocaine, the amphetamines, lysergic acid diethylamide, and several other drugs which have become notorious through their being taken for non-medical reasons.

7.25 Control measures have been introduced for a variety of reasons. The chief concern has been antisocial behaviour. With alcohol, for example, it is an offence to drink so much as to become drunk and disorderly in public. Even if the amount consumed does not cause drunkenness as ordinarily understood, an offence will still have been committed if the amount drunk is sufficient to impair the driving of a motor vehicle. Chronic heavy drinking can lead to State intervention in accord with the Alcoholism and Drug Addiction Act 1966. This Act was not framed merely for the protection of the alcoholic and similar drug misusers; the protection of their dependents was clearly a major consideration. Again, legislation on alcohol reflects the view that youngsters lack the judgment needed for unobjectionable drinking. To discourage over-indulgence in alcohol, there are severe restrictions on its manufacture and sale as well as heavy taxation.

7.26 Legislation restricting the use of various other substances takes account of additional hazards. For instance, there are numerous drugs which may be obtained only through a doctor's prescription, on the grounds that laymen have insufficient knowledge of the difficulties of drug therapy for them to be able to use the more potent agents with reasonable safety. Drug manufacturers are forbidden to market preparations which have not gained the approval of drug assessment committees. Even if a new compound is not being introduced as a medicine, its use for such purposes as insect or crop control may be restricted or forbidden if this involves a health hazard. Disastrous experiences with such chemicals as thalidomide have emphasised the need for comprehensive toxicity studies. The availability of drugs with addictive properties is even more tightly controlled.

Potential for Harm

7.27 The chief justification for drug control measures is possible harmfulness. Unfortunately, it is not a simple issue (see also section 4.59 to 4.76). To assert that a particular chemical is "toxic" is meaning-

ful only when such details as the dosage and frequency of administration are added. All substances are harmful when taken in sufficiently large amounts. There are several important drugs which would cause death if given in doses which are no larger than the minimum lethal doses of many of the substances which the layman would regard as poisons. Nevertheless, most drugs can be taken with little risk because the therapeutic dose is much less than a dose which would be toxic for most patients. Clearly, toxicity must be considered in relation to the normal or proposed usage of a compound. It is also essential to consider both acute and chronic toxicity. Thalidomide and lead are but two of many substances with harmful actions which are not quickly apparent. Again, it is clear that harm may not be confined to the person who takes the drug. An intoxicated motorist is a menace to others on the highway; a heroin addict can be driven to criminal acts for fear of the misery resulting from being deprived of the drug. It follows from such considerations that harmfulness must be viewed in context. We need know much more than what effect a normal dose of the drug will have on a normal person in a normal situation.

7.28 Nicotine, the chief constituent of tobacco, is so poisonous a chemical that its use in concentrated solution for horticultural purposes is now severely restricted in New Zealand. However, the amount of nicotine entering the body when tobacco is smoked is so small that only the neophyte is likely to find the effect distressing. In practice, then, the acute physical toxicity of tobacco is unimportant. The danger of tobacco smoking lies in its long-term effects. It is now almost indisputable that habitual smoking is detrimental to health. A person who smokes 20 or more cigarettes daily is far more likely than a non-smoker to fall victim to lung cancer or chronic bronchitis. He becomes more vulnerable also to such disorders as coronary artery disease.

7.29 Ethyl alcohol, the chief constituent of alcoholic drinks, is much less toxic than nicotine on a dosage basis. However, indulgence in alcohol leads not infrequently to physical distress within the next few hours. Alcoholic "hangover" is too well known to need description. Many persons have severely poisoned themselves through drinking too much alcohol on occasions. Chronic heavy drinking is detrimental to health, especially when complicated by malnutrition and self-neglect. It does not follow, however, that drinking alcohol in moderation will produce appreciable—though lesser—harm. According to insurance statistics, the abstemious drinker lives as long as the teetotaler.

The Case of Cannabis

7.30 From the standpoint of short-term physical toxicity, cannabis shows up well in comparison with alcohol. As mentioned in the first part of this section, death from overdosage is almost unknown. Most adverse reactions have been psychological. Panic states and even psychotic episodes may occur, but their incidence is low. It now seems unlikely that the risk of acute intoxication leading to serious antisocial behaviour is greater with cannabis than with alcohol.

7.31 There is still little that can be asserted with confidence about the long-term toxicity of cannabis. However, intermittent or even moderate use is not obviously harmful. Although there seems to be

much the same connection between heavy consumption of cannabis and "potheadedness" as there is between heavy drinking and alcoholism, it cannot be claimed on the basis of existing evidence that chronic heavy use is more likely with cannabis than with alcohol to lead to the deterioration of mental or social functioning. Even though it may be confirmed that the long-term use of cannabis preparations can be physically damaging, this hardly constitutes strong grounds for denying its use—at least so long as the use of tobacco carries no legal penalty despite the risks to which the habitual smoker exposes himself.

7.32 Other grounds must be sought for maintaining strong legal sanctions against the use of cannabis if these sanctions are to be respected by most of the community. There are several.

7.33 Curse though it be, the abuse of alcohol is mitigated by the control measures already mentioned. Thus many a celebrant must recently have decided not to drive himself home on realising or being persuaded, that he could not pass a "breathalyser" test. It is easy to detect and provide proof of alcoholic intoxication. Youngsters are deterred from performing rash experiments with alcohol because the chances of their being caught are so great.

7.34 From the standpoint of law enforcement cannabis provides far more difficulties than alcohol. It would be impossible without having the resources of a very well-equipped laboratory to provide pharmacological proof of intoxication with cannabis. Preventing its use by minors would be all the more difficult because cannabis is so much more potent than alcohol on a weight basis that it is easy to conceal the former in amounts sufficient to cause gross intoxication. Moreover, the cannabis plant can be grown so easily that it would be almost impossible to control the supply of the drug once its use was tolerated. Unlike alcoholic drinks, cannabis cannot be standardised without great difficulty or kept without deterioration under ordinary storage conditions. In these circumstances it is easy to misjudge dosage. It is not unusual for a marijuana smoker to think that his reefer must have been spiked with heroin or some such drug when in fact he has for the first time smoked a potent preparation.

7.35 If it is accepted that from a pharmacological viewpoint cannabis is not very different from alcohol, it would seem reasonable to use the legal offences arising out of the abuse of alcohol as the basis for defining similar offences arising out of the abuse of cannabis. However, this would not be practicable before the overcoming of the formidable technical difficulties which would be provided by attempts to police these regulations; so one great danger of easing present restrictions on the availability of cannabis would be widespread abuse of the drug stemming from the near impossibility of enforcing any control measures.

7.36 Another difference of practical importance between alcohol and cannabis is that alcoholic drinks are not used solely as intoxicants. Some at least have a wide appeal because of their savour. For instance, few eyebrows would be raised by someone claiming that after a hot day in the garden he found nothing slid down the gullet more pleasantly than cool beer. Only a minority of persons taking wine with a meal do so with the intention of becoming "intoxicated" as is

usually understood. With cannabis, on the other hand, the aim is an altered state of consciousness. Hence there is no need to consider unobjectionable uses, as with alcohol.

7.37 Yet another clear distinction to be drawn between alcohol and marijuana is that alcohol cannot in all circumstance be considered as a drug. It provides seven calories per gram and alcoholic drinks can be utilised by man as a source of energy. Taken temperately, and particularly in the context of a meal, the pharmacological effects are minimal. Alcohol then is undoubtedly acting as a food. In some wine-growing countries alcohol may provide up to 10 percent of the total national supply of calories.

7.38 In many parts of the world country beers and toddies are made by fermenting cereals such as maize, millets, rice, or the sweet saps of palm trees, and, besides supplying calories, may also provide thiamine, riboflavine, nicotinic acid, and ascorbic acid in amounts nutritionally significant.

7.39 While alcoholism stems from the abuse of alcohol as a pharmacological agent, the role of alcoholic beverages as foods should not be disregarded: marijuana is always a drug.

7.40 One important non-pharmacological reason for treating cannabis and alcohol differently stems from the social context. The risk of a particular drug causing widespread harm depends not only on the pharmacological properties of that drug but also on the number of vulnerable persons exposed to its use and on popular ideas concerning its desirability. The social setting has become increasingly important; one can speak without much exaggeration of a "drug mania". For a significant minority of young people drugs are "in". Their determination to experiment with drugs is hardly affected by the knowledge that several pop stars have killed themselves in this way, as have young people within New Zealand. Rather it seems that the publicity given to such cases makes drugs appear all the more glamorous. A complication is provided by the emergence of a youthful sub-culture whose members are at loggerheads with "the establishment" and for whom the marijuana issue is merely part of a campaign against authority. Marijuana is not only a drug; it is also a symbol.

7.41 Unfortunately, the situation has been bedevilled by ill-informed propagandists. Youngsters are tending to minimise the risks of drug-taking, not only because of the natural optimism of youth, but also because they have reason to doubt much of the information received from adults who obviously lack first-hand knowledge of the situation. As the Shafer Commission have pointed out, two mythologies now exist. In one of them cannabis is unduly blackened, in the other it is whitewashed. One tenet of the newer mythology is that marijuana use is unrelated to the use of other drugs. For instance, it is widely believed that persons who smoke marijuana tend to avoid alcohol. Major surveys are showing this to be untrue. The old stepping stone theory has been discredited to the extent that it can now be asserted that only a small proportion of persons who have tried cannabis subsequently become heroin users. It must be remembered, however, that few of those who try cannabis become heavy users of even that drug. Once again we have to take account of the drug, the set and the settings. For a youth with a vulnerable personality belonging to a group which can procure various

psycho-active drugs, the risk of escalation from marijuana to drugs like heroin must be considerable, especially if the discrediting of the earlier myths about marijuana cause him to underestimate the danger of getting hooked on narcotics. It is easy to lose sight of the persons at risk because of the much larger number of those who try such drugs as marijuana for the same reasons as induced many Americans during the days of Prohibition to try bootleg whisky or bathtub gin.

7.42 One other point: the use of alcohol and tobacco has become so much part of our way of life that prohibition of either in the near future is not practical politics. That is not to imply that the committee is resigned to indefinite continuance of the status quo. As indicated in the section on legal considerations, we believe that the abuse of alcohol and tobacco can be substantially reduced by measures other than prohibition by law—the best sanctions are not necessarily legal ones.

7.43 Whether the use of cannabis in New Zealand has become so widespread that the habit must be regarded as ineradicable is uncertain. Since we support legislative measures aimed at strongly discouraging the habit, we recommend continuance of a prohibition policy so long as this can be shown to be largely effective. However, we agree with critics of existing regulations that it is anomalous to class cannabis with narcotics like heroin. Our detailed proposals (set out in section 4.79.1) include recommendations for removing this anomaly.

7.44 The committee would draw attention to a matter which has been a subject for comment on a number of occasions at meetings of the International Narcotics Control Board. The countries with the longest history of involvement with cannabis in all its forms, including hashish, are in the forefront of those most actively seeking to discourage its use and to maintain suitable controls. Generally, these countries are poor in terms of resources and per capita income compared with many North American and European countries but, despite this economic disadvantage they are prepared to devote what is, for them, considerable resources in money and manpower to the development of substitute crops and eradication of illicit traffic. These countries, which have the greatest experience of the long-term effects of cannabis usage, are striving most for its control, while some affluent countries with little experience of the long-term effects have the largest and most vocal minorities.

8. EDUCATION ON THE USE OF DRUGS

8.1 In its first report (15.15-15.20) the committee stressed the importance of a well-planned and active programme of public education in the proper use of drugs and set out some of the requirements, as it saw them, for success in this field. These included the need to take into account the general public over-reliance on drugs and not just certain types of drug misuse; the need for adequate professional education for medical practitioners, lawyers, teachers, social workers, and others involved in the field; the need for adequate and correct information in all drug education programmes, and the need to tailor particular programmes to meet the requirements of different sections of the community—including children, young adults, and older persons. The committee has maintained its interest in this whole field since its first report was published. It has noted the increased emphasis given to education in a wide range of reports published overseas by United Nations agencies, national commissions and committees, Government departments, and a wide variety of private organisations.

8.2 There is a general emphasis in these reports on the importance of educational programmes in limiting drug misuse, but they vary considerably in the approaches which they recommend, and in the quality of evidence which they give to support their particular proposals. The field of drug education has become a battleground between those who see the real dangers of drug misuse and emphasise the importance of warning people from it by all the available methods of persuasion, and those who believe that the educator should present the objective facts and leave people to reach their own decisions. Much of what has been written in support of one or the other of these two positions has given insufficient attention to the valid points made by the other camp. A proponent of the "persuasion" approach who wishes to be taken seriously by those who are responsible for planning and introducing drug education programmes must show that he knows of the limited success of this technique in resolving other social problems, and he must indicate how he would overcome, or at least minimise, these failures. He must also show why the particular attitudes which he wishes to inculcate should be accepted by others. A proponent of the "permissive" approach must show that he has faced the fact that there are many aspects of drug misuse on which there are few, if any, hard facts and that it is not possible for any teacher to exorcise his own feelings and attitudes completely from his lessons. He must also satisfy the many classroom teachers who take their pastoral responsibilities seriously, and who feel that, if they and other concerned adults do not give their pupils some guidance, the gap will be filled by the vocal minority with firm views of their own who have no inhibitions about expressing them, and by the mass media.

8.3 As might be expected, the same wide range of approaches has been noted in the large volume of teaching materials which the committee has examined. This material has been produced in New Zealand and overseas by official and private agencies. It varies greatly in standards of production, factual accuracy, quality of illustrations and its appropriateness for its intended audience. In the committee's judgment some of this material, including the section on drugs in the New

Zealand edition of *The Little Red School Book*, is of a high standard but a regrettably high proportion is not. One serious criticism of some of the educational material which the committee has studied is that its over-emphasis on the physiological and psychological effects of those drugs which are misused mostly by younger people, and its comparative neglect of other facets of drug misuse, may unnecessarily stimulate experimentation with the drugs against which it is directed.

8.4 There is a very real risk that much of what passes for health education material in the field of drug use may prove counter-productive. This very point was stressed by Mr Carl Schurmann, personal representative of the Secretary-General for the United Nations Fund for Drug Abuse Control, when he visited New Zealand in 1972. Mr Schurmann made several references to a pending symposium on drug education to be sponsored by the Fund, which will be followed by a seminar in the same field. The dual purpose of these meetings is to re-examine the whole question of how drug education programmes can be best presented and the likely results of different techniques.

8.5 There is still a real shortage of educational materials dealing with the proper use—as opposed to the misuse—of drugs and of material aimed at those who use to excess the more commonly prescribed drugs such as hypnotics, transquillisers, and stimulants or others, including alcohol, which are available for public purchase. These may have much more serious effects on a user's capacity to cope successfully with the stresses of everyday life than the sporadic use of low grade marijuana.

8.6 The committee has subjected the material which it has received to careful scrutiny because it is aware that the health education material now being produced in New Zealand concerning the use of drugs could give rise to similar difficulties unless those responsible for its production have clear targets in view and give very careful attention to the presentation which they adopt. In response to recommendations made in our first report the Health Education Branch of the Department of Health has produced a handbook for health educators under the title *Use and Abuse of Drugs*, and the Departments of Health and Education have co-operated to produce guideline material for teachers, incorporating some of the basic handbook material. Both the departments consider this material to be at the pilot stage, and will be evaluating as fully as possible its effectiveness in use, with the aim of revising it in the near future. It is proposed that the Department of Health's material should be supplemented by an expanding range of leaflets, bookmarks, and other aids directed at different groups in the community.

8.7 The committee has welcomed the very considerable extension in secondary schools of programmes relating to the use of drugs as a reflection of the importance placed on this topic by teachers themselves. As it mentioned in its first report (15.18) the committee hopes that the programme will eventually become part of a recognised health education syllabus for secondary schools which will place the question of drug misuse in its proper context as one of the several important questions which young people need to consider as they prepare for life in the adult community.

8.8 Any adequate educational programme must be concerned not only with imparting information but also with the development of attitudes. This is a particularly important point for those programmes relating to matters such as the proper use of drugs, where individual people will finally decide their own course of action. Those who prepare the programmes face the challenge of being both factually accurate and of using those teaching techniques which will best help people to base their future behaviour on knowledge rather than prejudice or impulse, and on sound attitudes which they have accepted as their own. There is general recognition that this goal is best achieved by programmes which generate the active participation of those persons at which they are aimed, and hence the importance placed on discussion techniques.

8.9 Those who lead these discussions have the responsibility of ensuring that they do not intentionally or unintentionally try to impose their personal views on others, and that they give a fair survey of the different viewpoints on the matter concerned in the context of the available knowledge, be it the use of drugs, sexual behaviour, or some other aspect of social life. If they are to do this they must be adequately informed themselves. This requires, amongst other things, that they are provided with adequate resource material and with the best available information on the attitudes of New Zealanders towards the misuse of drugs. Those who must prepare this material cannot do so unless they, themselves, are aware of the actual climate of opinion in New Zealand, which is not necessarily the same as that given prominence through the press. It seems most important that the agencies responsible for the preparation of the materials used in educational programmes concerning the use of drugs should, as was mentioned in our first report (15.20), have adequate contact with the groups for which the programmes are prepared and particularly with those whose views are not likely to be ascertained through requests for oral or written submissions.

8.10 If this is to be achieved health educators will have to widen very considerably the techniques which they have used so far to inform themselves on the opinions and values of their groups which they hope to reach. Groups which seen to merit some priority for this attention include young people moving into the large cities to work, and those people of any age who are "at risk" of misusing drugs because they are under stress.

8.11 It is very easy for those who are concerned at the real dangers inherent in the misuse of drugs to look to a programme of public education as the panacea, and to place a particular responsibility on the schcool system to equip its students with a firm aversion from drug misuse. There is no doubt that schools can, and must play an important part in shaping public attitudes on important social issues of this kind, but available knowledge emphasises the very limited impact of school programmes which do not have community support or which operate in the face of non-supportive or antagonistic values brought before young people through other channels.

8.12 It is not within the terms of reference of the committee to report on questions of censorship but it considers that it should point out the undoubted impact, particularly on young people, of articles

and presentations in the mass media which overdramatise or over-emphasise some limited aspects of drug misuse. Such articles may work to the detriment of a sound public education programme. The community may well decide that this is an unavoidable price which must be paid to maintain that degree of freedom of the press considered important for the preservation of our way of life. The committee hopes that judgments on this matter will be made after taking into account the cumulative effect of any continuing imbalances in the presentation of matters relating to drug misuse in the daily newspapers and non-specialist magazines available to the general public.

8.13 The committee draws the attention of the Press Council to the very undesirable consequences of such an imbalance on the more impressionable sections of the community. There is a parallel danger of the press and the media generally alienating itself from the authorities with responsibilities for dealing with the drug situation. If the Press Council feels that the matter does not come within its terms of reference it would, nevertheless, merit the attention of the constituent bodies represented on it. The committee, likewise, commends the matter to the attention of both the NZBC and private radio stations which have at times erred by presenting insufficiently researched material, especially in news items, and in some special interviews and talks.

8.14 The committee has examined a number of films, currently in use in New Zealand, which deal with the question of drug misuse, dependency, and trafficking. In the view of the committee very few of the films most frequently sought for this purpose are free of serious difficulties in presentation. Those films that aim to present a broad aspect of drug misuse in prosaic and factual form are apt to be dreary and lacking in impact. Others err greatly on the side of generalisation and emotive appeal of a somewhat archaic quality, and the focusing on uncommon and relatively unfamiliar situations rather than presenting the common-place background that can be readily understood by the audience. The committee has noted with considerable concern the failure on the part of many people organising the screening of films relating to drug misuse to ensure that there is a well-qualified commentator present, capable and competent in the conduct of post-screening discussions. Even a mediocre film may be put to good use by a competent commentator, well versed and experienced in the field under review. Without a well-qualified commentator to guide discussion many drug films, even those of good and balanced quality, may prove to be the starting point of unnecessary curiosity.

8.15 The situation to which the committee wishes to draw attention has been expressed on page 390 of the second report of the National Commission on Marihuana and Drug Abuse entitled *Drug Use in America: Problem in Perspective.*

The Commission said:

"It seems reasonable to hypothesize that mood drug advertising at least reinforces certain drug attitudes among the young. The recipient may often get the message better and more accurately than the sender realises. The finding that users of illegal drugs tend to be more

receptive to pharmaceutical advertisements than non-users (Kanter, 1970) further suggests that advertising may serve to reduce internal conflicts by implying to users that everyone turns on in his own way.

"Although the Commission strongly urges against Governmental intervention, we do recommend that the media, on their own initiative, re-examine the impact of informational messages on youthful interest in psychoactive drugs. They should look not only at advertising but also at anti-drug public service announcements, at program content, and at news coverage of 'drug stories'.

"The Commission also recommends that in conjunction with their self-appraisal, the media sponsor and support long-term, longtitudinal research into effects of various communications on behaviour. Guided by the findings of these studies, the industry should take whatever corrective action is appropriate.

"With respect to proprietary, mood-altering drugs, the Commission recommends elimination from their advertising of suggestions that the substance can result in pleasureable mood alteration or deal with malaise caused by stress or anxiety. The 'feel better fast' pitch may encourage patterns of repeated use which, though begun with fairly harmless substances, may condition in the user a chronic drug-taking response to his or her problems."

9. SOME ASPECTS IN PERSPECTIVE

9.1 When the committee wrote its first report it commented that, while the misuse of drugs for non-therapeutic purposes was not then a major social problem in New Zealand, there were no grounds for complacency. The committee commented that it would be reckless to assume that drug misuse could be held static simply by strengthening measures for its control and treatment along the lines recommended in the report.

9.2 Subsequent events have confirmed this assessment. Although the controls exercised by the Department of Health, Police, and Customs over the availability of drugs liable to misuse have been considerably strengthened and considerable attention has been given to the treatment of those who have became involved in drug misuse, the number of persons charged with drug offences—a crude but valid statistic—has risen from 130 in 1969 to 706 in 1972.

9.3 Over the same period debate on particular aspects of the broad problem of drug dependency and drug misuse has continued among interested community and professional groups, with interest focused particularly on the status of cannabis as a "legal narcotic", the kinds of treatment programmes which should be made available, and the dimensions of an adequate preventive education programme in the proper and improper use of drugs. The Department of Health and several other agencies have published resource materials for this purpose, and the Departments of Health and Education have prepared material specifically designed to assist New Zealand teachers plan school programmes in this field. The overall results of this activity cannot be gauged. It has, hopefully, laid the basis for a sound beginning in the educational field and helped some members of the professions which are involved in the control or treatment of drug misuse to understand more clearly the full dimensions of this problem. But it has probably had little lasting impact on most citizens who have had to rely almost exclusively on the news media for their information. The committee comments in a number of places in this report on the role of the news media in this field. Its judgment may seem harsh, but the necessarily selective approach followed by newspapers, radio, and television in the great majority of their articles concerning drug misuse has not helped the general public to gain either a balanced appreciation of the problem or of the strength of its roots in our general way of life. Drug misuse has been presented primarily as a social incubus linked with the activities of a segment of young people who are socially deviant and not related in any causal way to the life-style of the ordinary newspaper reader, radio listener, or television viewer. It is outside his world, and somebody else's problem until it affects his own family or friends.

9.4 Although there is still a regrettable lack of reliable information on public knowledge about and attitudes towards drug misuse in New Zealand this analysis is probably still true for most young people. They may be more likely than their elders to discount official assessments of the potential dangers of drug misuse but most of them have not had personal experience with drugs of abuse other than alcohol. However, the proportion of young people who have misused other drugs has

undoubtedly grown very considerably over the past few years, particularly in the large centres where cannabis is usually available for those who wish to seek it, and the use of LSD has become fashionable in some groups.

9.5 The committee noted, in its first report, the limits of legal sanctions on private behaviour of groups who consider them unreasonable, and the likelihood of conflict of this kind over some aspects of drug use. The most volatile issue has been the degree of control which ought to be exercised over the use of cannabis. This matter is discussed in section 4.16 of our report. We wish to stress at this point that, while there are still sufficient reasons to warrant continued restrictions on the use of cannabis, those who take this view must recognise that it has no absolute valdity, they must be able and prepared to support it with facts rather than opinions, and they must be prepared to accept that some sensible and responsible persons will disagree with them and be prepared to discuss the issue on the basis of the available information rather than preconcieved attitudes. Otherwise the existing cleavages will harden and useful dialogue will become increasingly difficult to the ultimate disadvantage of all concerned.

9.6 The committee recognises that some people who have strong feelings on the known dangers inherent in misusing drugs will interpret a plea for an open dialogue on such matters as the control of cannabis as a retrograde step which can only weaken the chances of eradicating a growing social problem, by giving undesirable recognition to those who are flouting the law and the majority which support it. The facts are, however, that the misuse of drugs cannot and will not be eliminated by legal means alone, as experience both in New Zealand and overseas has shown; that it is now endemic in this country; and that the best prospect of reducing it lies in identifying and attacking the underlying causes. This will not be attainable unless open discussion of all viewpoints is encouraged, and reporting of such discussions is free of bias and selectivity in the media.

9.7 An effective programme to reduce the incidence of drug misuse must cover the field of control, treatment, professional and public education, research and the alleviation, as far as possible, of the conditions which lead some people to use drugs unwisely. New Zealand has made uneven progress across this field over the past 3 years. Its control procedures are well established and will be further improved, its treatment facilities have been extended although, as this report indicates, there is need for further development in community-based services. A useful start has been made in laying the foundations for a comprehensive education programme using the, as yet, limited resources available for this work, and a well-conceived though modest beginning has been made in research projects related to drug misuse. Perhaps because of the sheer lack of specific data and the consequent difficulty of knowing what could most usefully be attempted little, if any, progress has been made in the field of preventive social action. Drug misuse is not due solely to factors such as unhappy family backgrounds, educational failure, and the increasing size of our cities, but they do play a part of some importance. As the first report stressed, there is a need for very careful study of the possible relationships between the misuse of drugs and social factors of this kind.

9.8 Considered overall, therefore, the attack on the problem of drug misuse in New Zealand has, so far, been more obviously directed at treating the symptoms and outward manifestations. This is understandable in terms of meeting the immediate situation but it will prove increasingly inadequate unless as much or more attention is paid to research and action which attacks and, as far as possible, eradicates the underlying causes. There are considerable dangers in applying a medical analogy to the field of social behaviour, yet it has some relevance. Many of the advances in preventive medicine have come from the eventual identification of the causes of a disease and the development of techniques for their removal or control. In general this approach has worked best when it has not required any significant changes by people in their way of life as, for example, the control of smallpox. It has been less effective when it requires the active and continued co-operation of many people in areas they regard as their private and personal concern—as, for example, the control of venereal disease. We think there is an obvious lesson here for the treatment of drug misuse. It is a problem which has many facets and causal complexities, but the fact that so many of them are, as yet, hidden is surely all the more reason for trying to trace them.

9.9 The committee has given very careful consideration to the progress which has been made in the control, treatment, and alleviation of drug misuse since it commenced preparing its first report in 1969. It is strongly of the opinion that, while commendable progress has been made in some fields, there is little, if any, chance of halting, let alone reversing, the steady escalation in the misuse of drugs unless New Zealanders individually are prepared to meet the considerable cost of providing the broad and essential minima of treatment and research facilities now required and of developing an effective public education programme. These measures will not, of themselves, eradicate the problem of drug misuse but they will fill some very wide gaps in the resources now available for this purpose.

9.10 This second report contains a number of suggestions concerning the provision of better opportunities and resources for treatment and supportive facilities. The committee, as constituted, has neither the resources nor indeed the responsibilities to prepare a detailed programme of research into the social aspects of drug misuse. These are matters more appropriately left to the expertise of the many specialists concerned. However, the allocations of additional resources to them will prove to be of limited worth unless attention is also directed to the needs of a better organisation for joint planning, co-ordination, and evaluation across the whole field.

9.11 The committee has considered this matter fully in the light of its own experience and its assessment of future needs. It draws attention to the desirability of a much closer co-ordination of effort and responsibilities of the many Government departments, social agencies, and professional bodies who, in their respective fields, have direct or indirect responsibilities or involvement with the consequences of drug misuse to the individual and to the community.

9.12 The committee is hesitant to make any specific recommendations as to the form of organisation best suited to meet these needs

as it sees them. It does, however, draw attention to the benefits already stemming from an inter-departmental body in the field of drug intelligence, and suggests that a comparable organisation, serviced by the Department of Health, with appropriate appointments and a very modest establishment increase, is well worthy of consideration. Such an organisation could assist in bringing about a better and more speedy co-ordination of activities involving a number of Government departments, social and professional organisations, and voluntary bodies, all of whom may have a part to play in dealing with so complex an issue as the social roots, individual and community consequences, and cost of drug misuse. The organisation could also perform the important functions of collecting and disseminating reliable information on drug misuse more speedily than is now possible, and of providing machinery for the necessary co-ordination of the responsibilities and activities in the fields of health, education, social welfare, and justice of the Government departments concerned and the voluntary agencies working responsibly in this field. The committee believes that such an organisation could work effectively without impinging in any way on the statutory responsibilities of the departments concerned.

9.13 Because the issues involved are many and complex it would be essential that all those appointed to such a body should have adequate time free of other duties for its work (a minimum of 2 days a month), and should be appointed for a substantial period—certainly not less than 3 years.

9.14 In concluding its second report the committee recognises that there will be real and continuing need for an ongoing survey of the changing situation in the field of drug misuse which is beyond the resources of the committee as at present constituted.

9.15.1 It has noted that committees and commissions elsewhere that have undertaken responsibilities comparable to its own have had a limitation set to their term of appointment and that continuation of their work has devolved upon organisations within the framework of the federal or national governments of the countries concerned.

9.15.2 The form of any such organisation would need to be closely related to the pattern of central and local authority institutions' responsibilities as they are currently evolving in New Zealand.

9.15.3 Such functions as a National Drug Information Service responsible for isssuing technical information bulletins could well be linked to appropriate divisions within the Department of Health, acting in close collaboration with the Department of Education, medical and clinical schools and, perhaps, the Department of Scientific and Industrial Research. The Australian Drug Information Service might well serve as a model upon which a comparable New Zealand service could be based.

9.15.4 An organisation such as this would in several respects, be complementary to the role and responsibilities of the National Drug Intelligence Bureau who control in the field of illicit dealing. (Appendix IX.) It could also serve to reinforce the very valuable service provided by the Clinical Services Division of the Department of Health and the National Poisons Information Centre.

Recommendation

That consideration be given to ways and means of:

(a) Improving the collection and dissemination of reliable and factual information on the use and misuse of drugs;

(b) Providing for improved co-ordination of the activities of Government departments, professional and social agencies, and responsible and approved voluntary bodies working in this field;

(c) Strengthening the resources of the Clinical Services Division of the Department of Health in the first instance, and to the establishment of an appropriate organisation to ensure that the objectives of the committee are continued after the publication of the second report.

10. INDEX OF RECOMMENDATIONS

3. CHANGING TRENDS

That when next reprinted the Department of Health pamphlet *Guidelines to Health for International Travellers* be expanded to include advice on misuse of drugs and the often severe consequences of conviction against drug laws and Customs requirements in many overseas countries.

4. DRUGS AND THE LAW

1. That legislation relating to the control of drugs and similar substances (other than alcohol and tobacco) which have a significant potential for misuse should be incorporated into a single statute.

2. With regard to the provision and presentation of such legislation, we recommend:

(a) That the term "narcotic" should be avoided as far as possible or used only with its pharmacological meaning.

(b) That the drugs controlled be placed in several separate schedules (or parts of one schedule) which broadly indicate their relative potential for harm and degrees of control deemed necessary.

(c) That cannabis plant, but not cannabis resin (hashish) or extracts of cannabis, should be placed in a schedule (or part of a schedule) containing drugs with a lesser potential for harm.

(d) That differing maximum penalties, graded in severity, be provided for offences involving the possession or use of different drugs as scheduled in terms of their relative potential for harm.

(e) That the maximum penalty for the possession and use of drugs with the highest potential for harm should not be greater than the present maximum penalty for all cases of possession and use of controlled drugs.

(f) That the present policy of providing higher maximum penalties for offences of dealing in controlled drugs than for possession and use be maintained, but that differing maximum penalties, graded in severity be provided for dealing offences in terms of the relative potential for harm of the drugs concerned.

(g) That the maximum penalty for dealing offences involving drugs with a high potential for harm should not be greater than the present maximum penalty for all offences of dealing in controlled drugs, and that maxima for dealing offences involving drugs in schedules of lesser harmfulness be lowered where appropriate.

(h) That consideration be given to the suggestion that the illicit use or administration by injection of a drug prepared for oral use should be deemed to place it in a category of greater harmfulness carrying a higher maximum penalty.

(i) That a definition of "supply" and quantities of drugs, the illicit possession of which raises a presumption of dealing, should be made; and that, furthermore, smaller quantities should be set for those drugs having the greatest potential for harm, having regard also to the level of effective dosage involved.

In addition, for the consideration of the courts:

(j) That except in most unusual circumstances a penalty of imprisonment should not be imposed for the mere possession or use of a drug in a schedule of lesser harmfulness.

We further recommend:

(a) That provision be made for periodic review, in the light of developing understanding of drugs and of drug misuse, of both the classification of drugs and of the penalties which their illegal production, distribution, possession, and use may attract.

(b) That consideration be given to a review of the Alcoholism and Drug Addiction Act with the intention of adapting its provisions more closely to the changing situation in the field of drug misuse, with special reference to surveillance to follow supportive measures when need for inpatient care does not apply. (Section 10.)

(c) That the Department of Health take the initiative in exploring the development of non-legal sanctions against the misuse of drugs, with particular reference to the suggestions in section 4, paras. 82–88.

5. PRESCRIBING, DISPENSING, AND PROMOTION

1. That the committee recommends the attention of pharmaceutical manufacturers and promoters to the need to ensure that all promotional material intended for the medical profession be set out in such a way as to ensure that any possible adverse reactions and effects are given sufficient prominence. The material should constitute a balanced report on the properties of the drug for therapeutic purposes. In making this observation the committee recognises that, whilst many firms are meticulous in this regard, others would seem to observe a somewhat lower ethic.

2. That the content of all advertising of therapeutic drugs should be subject to a close and meticulous examination before publication to ensure that claims made are supportable in fact and that advertisements are not silent on any likely adverse effects. It is recognised that, in large measure, the NZBC already has a self-imposed code in this respect which is applied to such advertisements, and that this code has gone an appreciable way towards ensuring that only factual and supportable information is transmitted.

3. That the University Councils concerned provide for the upgrading of undergraduate programmes of pharmacology and therapeutics in New Zealand medical and clinical schools.

4. That the universities, in consultation with the New Zealand Council of Post-graduate Medical Education, be urged to assist with the furtherance of post-graduate education facilities, initially in each of the medical and clinical schools and, ultimately, in other appropriate centres.

5. That early attention be given to inaugurating a scheme whereby general practitioners attending approved post-graduate courses, and on

study leave, may have their expenses reimbursed in line with those obtaining in certain countries overseas, and whole-time hospital medical officers as appropriate could, with advantage, participate in such a scheme.

6. That, with a view to further encouraging maximal participation in continuing post-graduate education for the general practitioner, consideration be given to periodic bonus payments to practitioners who have fulfilled requirements of the Royal College of General Practitioners for continued membership of the college or to some agreed lower level of attendance related thereto.

7. That ways and means of improving existing post-graduate educational opportunities for medical practitioners and pharmacists be given due attention by the respective professional organisations, colleges and the New Zealand Council of Post-graduate Medical Education, and that the appropriate divisions within the Department of Health participate at some stage in such discussions.

8. That in any revision of legislation relating to the control of drugs with a significant potential for misuse and its eventual incorporation into a single statute, provision should be made in regulations to ensure that there are sufficient powers to control the not uncommon practice of persons seeking a controlled drug from a medical practitioner without declaring that they are already in receipt of supplies from another practitioner.

6. TREATMENT AND MANAGEMENT

1. That the level of financial support for the work of approved organsations, such as the National Society on Alcoholism and Drug Dependence and the Salvation Army, in the field of drug misuse be continued and augmented, subject to the ascertainment of need for particular projects.

2. That all such financial support be contingent upon the development and maintenance of patterns of liaison and full consultation and co-operation with health services and other approved and recognised agencies working in the same field.

3. The committee also recommends, both to the various organisations concerned and to hospital boards responsible for drug treatment facilities, that there should be closer co-ordination and consultation with the Department of Health in the interests of a better public understanding. This is particularly the case with public pronouncements for which widespread publicity may be accorded or sought.

4. That provision be made for at least one worker in the whole field of drug dependency and misuse to travel overseas each year to work in particular treatment centres, preferably on an exchange basis.

5. That the Department of Health should accept a continuing responsibility to:

(a) Foster and maintain consultation and liaison between the state and voluntary agencies involved in drug treatment programmes in each district;

(b) Maintain liaison with and between the staff of assessment and treatment centres on matters such as the criteria for determining those persons for whom opiates should be prescribed for the treatment of dependency.

6. That provision be made for full and continuing evaluation of drug treatment programmes.

9. SOME ASPECTS IN PERSPECTIVE

That consideration be given to ways and means of:

(a) Improving the collection and dissemination of reliable and factual information on the use and misuse of drugs;

(b) Providing for improved co-ordination of the activities of Government departments, professional and social agencies, and responsible and approved voluntary bodies working in this field.

(c) Strengthening the resources of the Clinical Services Division of the Department of Health in the first instance, and to the establishment of an appropriate organisation to ensure that the objectives of the committee are continued after the publication of the second report.

G. Blake-Palmer (Chairman).
F. N. Fastier.
W. E. W. Hurst.
J. A. Kilpatrick.
S. G. Little.
A. Joan Metge.
W. Murphy.
D. H. Ross.
P. P. E. Savage.
R. J. Walton.

May, 1973.

APPENDIX I

LIST OF WITNESSES PRESENTING SUBMISSIONS

Name or Identification	Place of Meeting Held	Date	Occupation or Tenor of Evidence
Professor D. L. Mathieson ..	Boardroom, Department of Health, Wellington	12 June 1970	Faculty of Law, Victoria University of Wellington
Dr R. G. T. Lewis	,,	,,	Wellington
Mr P. Caughley	,,	,,	President, Students' Association, Wellington Teachers' College
Mr T. Halligan	Connolly Room, Oakley Hospital	16–17 July 1970	Public Health Pharmacist, Auckland
Mr H. McGuire	,,	,,	,,
Dr N. McCallum	,,	,,	DSIR, Auckland
Dr D. Nelson	,,	,,	,,
Mr M. G. Law	,,	,,	Auckland University Students' Association
Mr L. Calder	,,	,,	,,
Dr C. Whittington	,,	,,	Oakley Hospital
Mr I. Vodanovich	,,	,,	Auckland Probation Treatment Centre
"A"	,,	,,	User Witness
Mr M. Howley	,,	,,	Customs Department
Detective Inspector Perry ..	,,	,,	Drug Squad, Auckland
"B"	,,	,,	User Witness
Mr Simmons	,,	,,	Alcoholism and Drug Addiction Information Centre
Rev. Fr L. M. McFerran ..	,,	,,	,,
Mr Aitken	,,	,,	,,
Dr W. S. Auburn	,,	,,	Auckland University Student Health Counselling Service
Mr J. Drummond	,,	,,	Senior Magistrate, Auckland
Dr W. Trotter	,,	,,	Medical Practitioner, Auckland
Mr P. Fletcher	,,	,,	Waikato University Students' Association
Professor B. James	Room 103, Chief Post Office, Dunedin	20–21 August 1970	Department Psychological Medicine, Otago University
Mr L. E. Millar	,,	,,	Otago University Students
Mr J. A. Howell	,,	,,	Students Accommodation and Welfare Officer, Otago University

Name or Identification	Place of Meeting Held	Date	Occupation or Tenor of Evidence
Mr S. E. Smith	,,	,,	General Manager, Kempthorne Prosser and Co's N.Z. Drug Co. Ltd.
Dr D. W. Strang	,,	,,	Physician in Charge, Student Health Services, Otago University
Dr C. Moore	,,	,,	Medical Superintendent, Cherry Farm Hospital
Mr W. A. Baylis	,,	,,	Chairman, Pharmacy Board
Professor C. W. Dixon ..	,,	,,	Head of Department, Preventive and Social Medicine, University of Otago
Sir John Walsh	,,	,,	Dean, Dental School, University of Otago
Mr D. H. McClymont ..	,,	,,	,,
Mr D. Cuthbert	Room 122 Bowen State Building, Wellington	24–25 May 1971	N.Z. University Students' Association
Mrs M. Logeman	,,	,,	,,
Mr J. Tanner	Ministerial Suite, Government Life Building, Christchurch	16 June 1971	Students' Association of the University of Canterbury
Mr D. Riley	,,	,,	,,
Mr A. Bradley	,,	,,	Student
Mr A. Duncan	,,	,,	Student
"C"	,,	,,	User witness
"D"	,,	,,	User witness
Rev. M. J. Goodall	,,	,,	City Missioner
Rev. D. C. Best	,,	,,	Curate, St. Matthews Church, St. Albans
Capt. M. G. Ramsay ..	Boardroom, Department of Health, Wellington	19–20 August 1971	1 Provost Company, Trentham
Mr T. Dyce	,,	,,	Lecturer in History, Victoria University of Wellington
Mr Brian Mills	,,	,,	President, New Zealand Jaycees
Mr H. A. Rollinson	,,	,,	Controller of Programme Services, NZBC
Mr R. Johnston	,,	,,	National Society on Alcoholism, Wellington
Mr P. Reid	,,	,,	,,
Mr F. H. Foster	,,	,,	Director, National Health Statistics Centre
Mr J. K. Baxter	,,	14–15 October 1971	Wellington—Personal viewpoint
Dr N. T. Barnett	,,	,,	Medical Officer of Health, Auckland
Dr A. W. S. Thompson ..	,,	7–8 December 1971	Director, Division of Clinical Services, Department of Health

Name or Identification	Place of Meeting Held	Date	Occupation or Tenor of Evidence
Sir Charles Burns	Boardroom, Department of Health, Wellington	7–8 December 1971	Director of Clinical Services, National Society on Alcoholism and Drug Dependence N.Z. Inc.
Detective Chief Inspector M. T. Churches	Boardroom, Department of Lands and Survey, Wellington	20–21 April 1972	Police Department
Chief Superintendent G. A. Dallow	,,	,,	,,
Detective Sergeant R. P. Thompson	,,	,,	,,
Detective Chief Inspector G. Perry	,,	,,	,,
Detective Sergeant B. J. Stewart	,,	,,	,,
"E"	Boardroom, Ministry of Transport	8-9 June 1972	User witness
Dr A. W. S. Thompson ..	,,	,,	Division of Clinical Services, Department of Health
Dr A. H. Paul	,,	,,	,,
Dr P. McKinlay	,,	,,	,,
Dr D. A. Andrews	,,	,,	,,
Mr C. R. Henwood ..	Boardroom, Department of Health, Wellington	14 August 1972	Victoria University of Wellington
Mr I. H. Boyd	,,	,,	Director, Victoria University Student Services Welfare
Mr M. W. Capper	,,	,,	Counsellor, Victoria University Student Services Welfare
Dr J. E. Hardwick-Smith ..	,,	,,	Consultant psychiatrist, Victoria University Student Services Welfare
Mr A. Laidler	,,	,,	Head of Physical Welfare Service, Victoria University Student Services Welfare
Dr M. J. Sparrow	,,	,,	Medical Officer
Miss R. E. Swatland ..	,,	,,	Head of Counselling Service, Victoria University Student Services Welfare

OVERSEAS PERSONS AND ORGANISATIONS

Name	Place Meeting Held	Date	Organisation
Brigadier J. Monk	Boardroom, Department of Health, Wellington	8–9 February 1972	Salvation Army, Canada
Dr G. Milner	Department of Health, Wellington	19 May 1972	Senior Specialist in Drugs of Dependence, Commonwealth Department of Health, Canberra
The Hon. Raymond P. Shafer	Boardroom, Department of Health, Wellington	29 June 1972	Chairman, US National Commission on Marihuana and Drug Abuse Fund
Professor Maurice H. Seevers	"	"	Member, US National Commission on Marihuana and Drug Abuse
Dr J. Thomas Ungerleider ..	"	"	Member, US National Commission on Marihuana and Drug Abuse
Mr Michael R. Sonnenreich ..	"	"	Executive Director, US National Commission on Marihuana and Drug Abuse
Mr C. W. Schurmann ..	Department of Health, Wellington	11 July 1972	United Nations Representative for Drug Abuse Control
Mr James M. Ch'ien ..	Boardroom, Department of Health, Wellington	7 September 1972	Superintendent of Social Services, Society for the Aid and Rehabilitation of Drug Addicts, Hong Kong
Miss Eva Leung	"	"	Social Worker, Society for the Aid and Rehabilitation of Drug Addicts, Hong Kong
Miss Lydia King	"	"	"

APPENDIX II

THE CHANGED IMAGE OF DRUGS

PERSONAL COMMUNICATION TO THE CHAIRMAN FROM MEDECIN-COLONEL P. DE CARFORT, CONDOMINIUM CHIEF MEDICAL OFFICER, PORT VILA, NEW HEBRIDES, 25 MAY 1972. (ORIGINAL: FRENCH.)

"What disturbs me at the present time is that the image of "the drug" has changed. I have known plenty of drug users in the past. It then was a matter of people who used drugs voluntarily at a certain age in their life, to assist in coping with hunger as with the Indians of Bolivia, or to calm moral or physical suffering or, even more simply, a particular acute distress. Afterwards, to be sure, it would be necessary to "ease" the habituation and the dependency. There are also those who smoked, from nostalgia for the happier times they had known in Asia.

"In our time drugs have become, above all, the thing of the young. They are carried away with it among themselves and this serves to band them more closely together. And to be sure there is a whole organisation which makes use of this propensity for profitable ends, with drug "pushers". It is no longer simply a spontaneous adherence, it is a collective involvement manipulated by a few "pushers".

"Drug involvement itself has changed because it is no longer a simple matter of lesser drugs and opium but almost everything in the drug field. One no longer seeks pacifying contentment of the opium pipe taken in privacy and often alone. The search is for group chemical intoxication. Furthermore, before habituation or dependency, before being hooked on heroin for example, many young persons drug themselves just as assiduously with aviation glue or with datura, or with elixir of paregoric or even, what is much more serious, with the amphetamines for which "detoxification" is so very difficult.

"It is indeed group polytoxicomania.

"Ethno-sociologists in France, and perhaps elsewhere, speak of the crisis of civilisation but is it not rather a crisis of youth in our civilisation? They explain this as a crisis of confidence in the values taught, the rejection of the fundamental values which have made our civilisation. They say, also, that the present day youth is not satisfied with what they see and what they hear and, feeling themselves opposed to this, seek refuge, by the grace of drugs, in an imaginary life which seems more worthwhile than the real life.

"I am very wary of the sociologists for a large proportion of them have a tendancy always to throw the blame on others.

"Idleness or sloth, the easier life, abdication of responsibility of many parents and teachers, may well have a part in this as have such physical aggressions as noise, excessively bright and sparkling lights, radio and television transmissions or such moral aggressions as way out flashy publicity, films and the yellow press. All the time the drug misuse continues and enlarges. Its roots and ramifications become more and more closely knit, but what should be done? The English (in 1969, I believe) promulgated a Misuse of Drugs Act. I shall be

curious to know the results. England also had, in effect, a significant number of drug misusers in 1969 following, amongst other things, the massive Pakistani and Indian immigration to England.

"Perhaps remedial action would be easier if there were more solid supportive structures within our society, but the parents often opt out, the teachers have lost their role as educators, the politicians flatter the young because they represent a mass of future electors. In brief, the greater part of the people, on appeal to their personal sense of obligations and responsibilities, wish to misunderstand the dangers of drugs, and some, seeing this as an exploitable market to be used, reject the dangers and seek to absolve themselves by fallacious arguments.

"I have been perhaps a little talkative, my dear colleague, and ask you to excuse me. The New Hebrides are passing through an epidemic of dengue fever of no great gravity. Suicide by nivaquine becomes frequent with 30 cases in five years . . ."

APPENDIX III

SOME RECENT REPORTS AND PUBLICATIONS

By F. N. Fastier Professor of Pharmacology, Otago University

Since our first report, much has been written about the non-medical use of drugs—so much in fact that it would be impossible to read all the articles, let alone review them properly. Many of these articles contain original laboratory or clinical observations, but most are essentially polemical. That is to be expected. Such an important and complex problem as drug abuse is bound to generate some contentious opinions. Unfortunately, it is easy for a layman to get a badly distorted view of the situation. He might well imagine, if his information were confined to items provided by the ordinary news media, that experts were divided into two groups holding completely incompatible views. This is far from being the case.

Although the "marijuana issue" is undoubtedly a very important one, it is a single facet of the problem of drug abuse. Few of the persons who advocate the "legalisation" of marijuana would want a comparable easing of restrictions on the use of such drugs as heroin and cocaine. A deplorable consequence of the credibility gap which has been opened up between ill-informed partisans in the marijuana controversy is that youngsters have come to discount the very real risks associated with the taking of LSD, amphetamines, and the like. What is worse, attention has been diverted from the chief factor in drug abuse, which is the vulnerable person, to particular drugs.

Reports of National Committees

Among the mass of recent publications there are a few of cardinal importance. These are reports of national committees which have had exceptional opportunities for studying the phenomenon of drug abuse and getting it into perspective. Particular attention will be given here to reports from Canada and Australia, since these countries closely resemble New Zealand in many respects.

The Le Dain Interim Report

In 1969 the Canadian Government set up a Commission of Inquiry into the Non-medical Use of Drugs. As chairman it appointed Gerald Le Dain, the Dean of Law at York University, Toronto. This explains why the Commission's first report has become widely known as the "Le Dain Interim Report". This commission has since produced two further reports, one dealing with cannabis, the other with treatment.

The interim report (which can be bought in New Zealand) contains in its 335 pages not only much factual information but also frank discussion of attitudes and problems. The longest of its six chapters describes the effects of those drugs which are commonly used for non-medical purposes. Canadian patterns of drug abuse are dealt with in another chapter and legal policy in a third. For a New Zealander the most interesting chapter is that in which the commission has tried to identify the issues and made a number of recommendations.

They see non-medical drug use generally as "presenting a complex social challenge for which we must find a wise and effective range of

social responses . . . . emphasis must shift, as we develop and strengthen the non-coercive aspects of our social response, from a reliance on suppression to a reliance on the wise exercise of freedom of choice . . . Our own view is that while we cannot say that any and all non-medical use of psychotropic drugs is to be condemned in principle, the potential for harm of non-medical drug use as a whole is such that it must be regarded, on balance, as a phenomenon to be controlled. The extent to which any particular drug use is to be deemed to be undesirable will depend upon its relative potential for harm, both personal and social."

Though noting that Canadian society is very heavily involved in non-medical drug use of all kinds, and though seeing the inconsistency of condemning certain forms of drug misuse while tolerating others, such as abuse of alcohol or of tobacco, the commission nevertheless felt that "society is not obliged to repeat its errors". Hence its attitude to the use of cannabis is one of caution. As they say, "the existing evidence, such as it is, affords no clear guidance for predicting what would be the long-term effects of cannabis use at various levels of dose and frequency. It is probably fair to say, however, that such evidence as there is affords the basis for a cautious rather than an optimistic approach". The commission gave several reasons for its not being prepared to recommend the legalisation of cannabis for the time being, including the lack of informed debate and the technical difficulties which would have to be faced if the Government assumed responsibility for the quality control and distribution of cannabis. On the grounds that "cannabis is clearly not a narcotic", the commission recommended that the control of cannabis be removed from the (Canadian) Narcotics Control Act and placed under the Foods and Drugs Act.

Report of the Australian Senate Select Committee

This was published in 1971 under the title "Drug Trafficking and Drug Abuse". Unlike most other national committees, the Australian one consisted entirely of laymen. The 8 senators who comprised it took evidence from a wide variety of sources in the course of hearing 213 witnesses. The transcript of their evidence totalled over 6,400 pages.

The chief conclusion of the Australian Senate Select Committee was that "the abuse of drugs is more a people problem than a drug problem and it therefore follows that the main purpose of legislation should be to control the supply of drugs which can cause harm to people rather than to provide a penalty system for those who disobey the law by using drugs illegally. The aproach to the drug taker should be one with emphasis on treating an illness rather than imposing a penalty for a wrong doing. . . . There should be a more humanitarian approach to the treatment of the young drug abuser appearing before the court."

As regards the extent of the problem, the Senate Select Committee concluded that separate circumstances apply to the under-25-year and the over-35-year age groups of drug abusers. Although the younger age group is smaller at present, this is the group for which there is a serious risk of escalation. As yet the use of illegal drugs in Australia

has not reached the epidemic proportions being experienced in certain other parts of the world.

The Senate Select Committee concluded that existing education programmes aimed at correcting drug abuse were inadequate. It saw a need for specially planned programmes designed to reach specific age groups and co-ordinated by one national group.

Although the committee accepted that in the present stage of knowledge marijuana is not as dangerous as has been frequently publicly proclaimed, it concluded that "scientific evidence is not yet sufficiently conclusive to warrant, with safety to the public, the removal of existing restrictions on the use of any of the cannabis derivations".

Three Reports Compared

It is interesting to compare the conclusions and recommendations of these two reports with those contained in our own first report. The similarity is close. Thus all three committees have concluded that there is no single or simple explanation of drug abuse available. They consider it a problem which must be studied in its total social context—and that includes attitudes and practices regarding the use of alcohol and tobacco as well as drugs prescribed by medical practitioners to deal with pain, stress, or frustration. Believing that causal factors are to be found at individual, group, and society-wide levels, the committees recommend broadly based educational programmes. Particular programmes should reach not only the potential victims in different age groups but also such persons as teachers, medical students, and medical practitioners. Since the information provided be timely and credible, each committee saw a need to obtain through research more reliable knowledge about certain drugs of abuse and also about drug abusers.

As regards legal aspects of the non-medical use of drugs, the common view was that the punitive approach is of very limited value and that harsh penalties are to be avoided in the case of most young offenders, at any rate so long as the offence is simple possession (as distinct from drug pushing or drug trafficking). Rehabilitation was seen as a more important aim than "making an example".

Each committee evidently heard witnesses who challenged the appropriateness of employing legal sanctions against non-medical drug use. Should "private offences" come within the scope of the criminal law? Like the British Advisory Committee on Drug Dependence which issued the Wootton report but unlike the New Zealand committee in its first report and the Australian committee, the Canadian Commission discussed the divergent legal philosophies (highlighted in the Hart-Devlin controversy) concerning conduct appropriate for criminal law sanction. Their discussion (pp. 34–252) of this "law and morals" issue cannot usefully be submmarised. It is well worth reading in full. It led them to conclude that the state should not be denied the right to use the criminal law to restrict the availability of harmful substances (particularly to young people) and to protect itself from certain kinds of harm. Although they also considered that the "harm caused by a conviction for simple possession appears to be out of all proportion to any good it is likely to achieve in relation to the phenomenon of non-medical drug use", the commission was "not prepared to recommend the total repeal of the prohibition against

simple possession without an opportunity to give further study and consideration to:

(a) The possible effect of permitted use on the nature and development of trafficking; and

(b) The possible effect of the lack of an offence of simple possession on the effectiveness of law enforcement against trafficking."

Noting that the total number of cannabis users brought to court in Canada was conservatively estimated as under 1 percent, the commission pointed out that a law applied so infrequently in relation to the number of offences is "bound to create a strong sense of injustice and a corresponding disrespect for law and law enforcement". The same point was made in sections 15.10-15.14 of our first report.

The Final Le Dain Report

This is being published in sections dealing with particular facets of the non-medical use of drugs.

The section entitled "Cannabis" runs to 403 pages. Since it was published late in 1972, it gives an almost up-to-date account of the properties of cannabis. The commission was so concerned with filling in certain gaps in our knownledge of cannabis that it instigated several sets of well-controlled experiments with humans. The results of these studies are described, as are those of sociological studies on patterns and extent of use, also carried out under their auspices.

For the general reader the most interesting part of the cannabis report is that dealing with legal issues. The commission raised such questions as the following: "What consequences of behaviour are we to regard as legitimate grounds for social concern? What, in the light of these criteria, are the facts concerning cannabis? What should our objective of social policy be? What instruments of social policy are available to us? What criteria are to determine their appropriateness?".

The majority of the commissioners concluded that there are serious grounds for social concern about the use of cannabis, that the focus should be use of cannabis by adolescents, and that the principal object of social policy "should be to restrict its availability to them as much as reasonably possible by the methods which appear to be the most acceptable on a balance of benefits and costs". They, therefore, recommended continuance of the policy of prohibiting the distribution of cannabis, but reduction of the penalties for illegal distribution. On the grounds that the "cost to a significant number of individuals, the majority of whom are young people, and to society generally, of a policy of prohibition of simple possession are not justified by the potential for harm of cannabis", three of the five commissioners recommended the repeal of the prohibition against the simple possession of cannabis. One of the two other commissioners went so far as to recommend that restrictions on the use of cannabis be reduced to make them similar to those controlling the sale and use of alcohol. However, the other dissentiant recommended maintaining prohibition of the simple possession of cannabis, giving as his princpal reason "a fear that a repeal of the prohibition of simple possession, at this time, would be apt to be seriously misinterpreted, particularly by young people. . . . Unfortunately, a repeal of the prohibition could too easily be taken as reflecting a judgment that cannabis is indeed safe. It is not realistic to expect that the balanced discussion

of the drug's effects and potential for harm in this report will be read in detail by many potential users. The press is not likely to report in full our statements about the known and potential dangers of cannabis."

While the treatment report is of more specialised interest, some of the problems tackled by the commissioners raise issues which are of fundamental importance. For instance, what right has the community to insist upon the treatment of an individual who does not believe himself to be the victim of an illness or to be a social misfit. Here again it would not do justice to the commissioners to attempt to condense material which ought to be read in full.

Reports on Marijuana

Most of these are concerned chiefly with scientific findings, which are discussed elsewhere in this report (section 1). However, one from the United States needs mention because of its scope and because of the expertise available to the commission. This is the first report of the National Commission on Marihuana and Drug Abuse: *A Signal of Misunderstanding.* It was published in March 1972 and is likely to become known as "the Shafer report" because the commission was chaired by the Hon. Raymond Philip Shafer, a former Governor of the State of Pennsylvania.

The Shafer report covers much the same ground as the Le Dain report on cannabis, it reaches similar conclusions, and it makes similar recommendations. In formulating a marijuana policy, the Shafer Commission was concerned principally with irresponsible use. It accepted that "the substantial majority of users, under any social control policy, including the existing system, do not and would not engage in irresponsible behaviour". It then considered the following policy options: approval of use, elimination of use, discouragement of use, neutrality towards use. The Shafer Commission concluded that the risks associated with the use of marijuana justified a policy of discouragement, concentrated primarily on the prevention of heavy and very heavy use. It felt that "the criminalization of possession of marihuana for personal use is socially self-defeating as a means of achieving this objective". Hence it recommended that possession of marijuana for personal use should no longer be an offence, though marijuana possessed in public should remain contraband subject to summary seizure and forfeiture. It also recommended, however, that cultivation, sale or distribution for profit and possession with intent to sell should remain felonies.

The second and final report of the United States National Commission on Marihuana and Drug Abuse, *Drug Use in America: Problem in Perspective,* was received at the same time that publication of this committee's second report was authorised by the Board of Health in June 1973.

Appropriately enough a major part of its deliberations and findings were directed towards the complex and massive problem of drug misuse in the United States attaining a greater uniformity within the legal framework of the 50 states of the Union and the Federal authorities. The whole emphasis is towards a greater examination of present approaches to treatment, examination of the psychological background, and rehabilitation with a move away from excessive reliance on punitive measures some of which, by New Zealand standards, may appear extremely harsh.

A review of treatment and rehabilitation in section 4 of chapter 4, "Towards a Coherent Social Policy", has much in common with some of the committee's views on treatment and management as expressed in section 6.

Mis-reports

The news media must accept some of the blame for the belief common among some sectors of the community that experts on cannabis are so hopelessly prejudiced that their views are suspect. Unfortunately, extremists on both sides tend to gain attention because their opinions are considered "newsworthy". Extreme views are held for the most part by persons who lack the experience and breadth of knownledge to see things in perspective. The "instant expert" has little reputation to lose if he demands that drug traffickers be lined up and shot or, alternatively, that all restrictions on the supply of drugs be removed, either on the grounds that each of us has an inalienable right to the pursuit of happiness, or on the grounds that making heroin and the like readily available would have eugenic effect in that the misfits would tend to poison themselves off before they managed to breed. Middle-of-the-road views do not make such interesting reading. To blame the press for this is to blame human nature. Nevertheless, the press has a duty to ensure, by means of editorials and statements from well-informed persons, that it presents well-balanced views on important questions.

Michael Schofield, who was one of the committee which compiled the Wootton report, has some hard things to say about the press handling of the report in his book, *The Strange Case of Pot*. Before the report had been published, guesses in newspapers had served to mislead the public about the recommendations and bedevil the issue. Alleged "leaks" of the Le Dain interim report have also served to generate confusion.

Those who point out that the marijuana issue has opened up a major "credibility gap" should define between whom this gap exists. Many frank partisans have been extremely vocal. However, one does not expect to get the whole truth from an extremist party.

APPENDIX IV

SOME NEW ZEALANDERS INVOLVED IN DRUG OFFENCES OVERSEAS

Since the publication of the first report an increasing number of New Zealanders have come to the notice of New Zealand missions abroad on account of their involvement in drug offences. As has been pointed out elsewhere in this report, penalties for drug offences under New Zealand legislation are among the lightest in the world, particularly in the case of offences involving use and possession. Furthermore, the procedures of justice in New Zealand and the determination of the cases of persons charged before the courts is fair, swift, and without the long delays that not infrequently obtain in many other countries overseas; particularly in Asia and many parts of Europe that appear to be favoured by some New Zealanders who are especially liable to find themselves involved in offending against the drug laws of the country concerned.

Whether or not such persons have been before the courts in New Zealand for drug offences or, having put themselves at risk have escaped detection, the penalties in New Zealand in the event of conviction, particularly for first offenders, are comparatively light. Similar offences in most other countries carry significantly heavier penalties and, furthermore, the procedures of justice are subject in many places to lengthy delays. Persons so charged may find themselves held in custody, often in most uncomfortable situations, pending the determination of their cases. In due course, such cases come to the notice of Ministry of Foreign Affairs staff in the nearest New Zealand mission. Even if the courts determine the case by way of a fine and an order for deportation, the fine may exceed the total resources of the traveller and the New Zealand mission is involved in providing the means of subsistence and often the cost of repatriation.

A few examples may show some of the consequences of offending against drug laws in a number of overseas countries. All concern New Zealanders travelling abroad since the publication of the committee's first report in 1970.

(a) Male—Arrested at Turkish/Greek border in May 1970 when a small quantity of hashish was found in a companion's rucksack. Released on bail late June 1970 conditional upon remaining in Turkey pending hearing. Case did not come up until September 1970 when he was acquitted of conspiracy charge in absentia.

(b) Male—Arrested by Malaysian customs mid May 1970 charged with possession of marijuana. Three weeks later found guilty, fined, and released. Subsequently subject of Interpol inquiry relating to marijuana and heroin. Arrested Bangkok in late January 1971 for possession of opium. Convicted and deported late March 1971.

(c) Male—Arrested in Beirut early March 1969 with substantial quantity of hashish in luggage. Convicted January 1970 and

sentenced to six months imprisonment for using hashish with a further 12 months for using hashish in prison while awaiting trial. The sentences ran concurrently.

(d) Female—Arrested early December 1969 in Italy together with three American males. Charged with possession and attempting to sell 14 kilograms of hashish. This case was not determined until late August 1970 after 9 months in prison awaiting trial. Ordered to leave Italy as time held pending trial exceeded sentence awarded by court. In the circumstances the additional fine was waived.

(e) Female—Arrested late October 1970 in Italy. Charged with possession of small quantity of hashish and distribution of drugs. Case was not determined until mid May 1971 when she was required to leave Italy within 5 days.

(f) Female—Arrested in the Netherlands on arrival by air from Afghanistan early December 1971 when found in possession of hashish. Case determined February 1972. One year's imprisonment reduced by period spent in custody.

(g) Male—Arrested late February 1972 in Germany on hashish possession charge. Considerable delay before case came before court.

(h) Male—Arrested Yugoslavia late December 1971 at Bulgarian border when small quantity of hashish found in car. Convicted 1 week later of breach of Customs regulations. Two months imprisonment in lieu of fine and car impounded. Early February 1972 found guilty of illegal possession of narcotics and sentenced to 10 months' imprisonment as from date of arrest. Appeal against sentence rejected.

(i) Male—Arrested Istanbul early November 1970 for possession of hemp seed. Six weeks later sentenced to 2 years, 6 months imprisonment.

(j) Male—Arrested Hungary mid November 1971 in transit from Lebanon to West Germany in possession of substantial quantity of hashish. Six weeks later sentenced to 9 months' imprisonment followed by expulsion from Hungary. On appeal in February 1972 reduction of crime to misdemeanour, prison term to remain of same duration but to be served in less severe prison.

(k) Male—Arrested London mid November 1970 in possession of several ounces of heroin. February 1971 sentenced to 3 years' imprisonment with recommendation for deportation on completion of sentence.

Cases referred to above are selected from those coming under notice to the end of the first quarter of 1972. Since that time quite a number of New Zealanders have been involved in drug offences in Asia, Europe, and North America, including at least two cases on dealing in which substantial amounts of drugs in the most strictly controlled categories were concerned.

New Zealanders Involved in Drug Offences Overseas Reported as at 15 May 1973

Table 1—Yearly Total of Court Appearances

1952	1
1955	1
1956	1
1962	1
1964	2
1965	5
1966	6
1967	11
1968	20
1969	25
1970	84
1971	105
1972	95
1973	13
	370

Table 2—Total Number of Offences as per Type of Drug Involved

	Prior to 1972	1972	1973 (to date)	Total
Cannabis	172	104	12	288
LSD	38	13	..	51
Heroin	17	4	..	21
Opiates	21	5	..	26
Prescription poisons	25	2	..	27
Possession of instruments ..	9	5	..	14
Type of drug not stated	85	21	1	107
Total	367	154	13	534

Table 3—Age Group and Number

Year of Birth	Prior to 1972	1972	1973	Total
1917	1	..	..	1
1928	1	..	..	1
1929	1	..	..	1
1931	4	..	..	4
1932	1	..	..	1
1933	1	..	..	1
1934	3	..	..	3
1935	1	..	..	1
1936	1	..	..	1
1937	1	..	1	2
1938	2	2	1	5
1939	8	3	1	12
1940	4	..	..	4
1941	3	..	..	3
1942	9	2	1	12
1943	5	3	..	8
1944	10	5	1	16
1945	5	6	..	11
1946	21	9	1	31
1947	17	10	..	27
1948	20	17	2	39
1949	15	14	..	29
1950	16	26	2	44
1951	16	23	..	39
1952	15	9	2	26
1953	5	7	..	12
1954	..	3	..	3
1955	..	1	1	2
1956	1	1	..	2
Not known	5	2	..	7
Total	192	143	13	348
Male offenders	155	130	13	298
Female Offenders	37	13	–	50
Total	192	143	13	348

APPENDIX V

NARCOTICS ACT 1965

USE OF POWERS OF SEARCH WITHOUT WARRANT

	Date	Location	Place	Result
1.	10/3/70	Auckland	House and grounds	Found in the grounds, 35 cannabis plants. Offender charged.
2.	12/3/70	Auckland	Grounds of house	Found at the rear of the house, 24 cannabis plants. Offender charged.
3.	20/5/70	Christchurch	House	Found in the bedroom, 18 cannabis seeds, 6.41 g of marijuana. Offender charged.
4.	5/8/70	Auckland	Flat	Found in flat, 2.08 g heroin, hypodermic needle, nine cannabis seeds. Offender charged.
5.	11/8/70	Dunedin	House	Found in kitchen, 0.3 g opium, marijuana reefer butts. Offender charged.
6.	21/8/70	Auckland	Vehicle	Found in the vehicle, three tablets LSD. Offender charged.
7.	23/8/70	Auckland	Vehicle	Found in the vehicle, 5 g opium. Offender charged.
8.	27/9/70	Auckland	Flat	Found in the flat and on search of person: 53 capsules containing LSD; 14 tablets containing LSD; 4 g cannabis and cannabis seeds; 5 tablets mogadon; 1 marijuana reefer butt. Offender charged.
9.	11/11/70	Dunedin	Motel	Found in a motel unit: 41.25 g marijuana; 22 cannabis seeds; 10 marijuana reefer butts. Offender charged.
10.	27/11/70	Auckland	Person	Found on search of person, nine marijuana reefers. Offender charged.
11.	26/11/70	Auckland	House	Found in the house: cannabis seeds; 2 g marijuana; traces of heroin; 14 hypodermic needles and syringe. Offender charged.
12.	16/11/70	Auckland	House	Found in the house: 58 g marijuana; two marijuana reefer butts; several cannabis seeds; one pipe for smoking marijuana. Offenders charged.
13.	26/11/70	Auckland	Flat	Found in the flat; 3.4 g marijuana; three marijuana reefer butts; cannabis seeds. Offenders charged.
14.	7/12/70	Auckland	Flat	Found in flat: traces of heroin on hypodermic syringe. Offenders charged.
15.	29/11/70	Dunedin	Person	Search made at police station but no narcotics found.
16.	22/1/71	Auckland	Person	Found following search of persons, 150 tablets containing LSD. Offenders charged.

	Date	Location	Place	Result
17.	23/1/71	Auckland	House	Following found on search of person: 0.8 g marijuana; 0.2 g hashish; six cannabis seeds; Offender charged.
18.	3/2/71	Auckland	House	Traces of opium—syringes and needle. Offender charged.
19.	18/2/71	Christchurch	House	Found in the house 2.2 lb hashish. Offender charged.
20.	18/2/71	Christchurch	House	No narcotics found but connected with search No. 19 where the hashish was to be moved from one house to another.
21.	28/2/71	Auckland	House	No narcotics found. Occupier admitted smoking marijuana at another location.
22.	18/3/71	Auckland	House	Found in a necklace 1½ oz hashish. Offender charged.
23.	23/4/71	Christchurch	Flat	Found in the flat, three hypodermic syringes, needles, and filters. Offender charged.
24.	25/6/71	Wellington	Flat	0.27 g hashish. Offender charged.
25.	3/7/71	Wellington	House	Six cigarettes which had been dipped in opium. Offender charged.
26.	8/10/71	Christchurch	House	Found in house and outbuildings: two hypodermic syringes; small residue of opium. Offender charged.
27.	5/11/71	Christchurch	Hotel	Found following search of person and hotel bar; two durophet capsules; 44 tablets which were being sold as mescaline but on analysis found innocuous. Offender charged.
28.	26/12/71	Wellington	Vehicle	No narcotics found in vehicle. Search followed finding of narcotics nearby.
29.	29/2/72	Christchurch	House and grounds	545 g of marijuana found outside rear door of house.
30.	8/11/72	Christchurch	House	Narcotics and prescription poisons stolen from chemist shop burglary recovered as follows: physeptone, methadone, opium, nepenthe, pethidine, omnopon, mandrax, valium, librium, tuinal.
31.	5/12/72	Auckland	Person	Two tablets containing LSD. One arrested.
32.	6/12/72	Christchurch	Motor hotel	192 tablets containing LSD and 0.3 g cannabis found in motor room. Two arrested.
33.	11/1/73	Queenstown	House	2.6 g cannabis found in bedroom. One arrested.
34.	12/1/73	Waiuku	House (commune)	12 cannabis plants and small quantity of cannabis found. Seven arrested.
35.	27/2/73	Wellington	Person	No narcotics found.
36.	2/4/73	Dunedin	Two vehicles and four persons	14 cannabis plants; 14.5 g cannabis.
37.	25/4/73	Wellington	House	No narcotics found.
38.	19/5/73	Auckland	House	½ lb cannabis; 1 LSD tablet; 92 cannabis seeds; 2 g hashish.

APPENDIX VI

PENALTIES FOR MARIJUANA OFFENCES IN A RANGE OF SINGLE CONVENTION COUNTRIES

Nation	Offences		
	Use or Possession for Personal Use	Possession	Sale
Australia ..	S 0–2 yr I 0–10 yr	S 0–2 yr I 0–10 yr	S 0–2 yr I 0–10 yr
Belgium ..	3 mth–2 yr	3 mth–2 yr	3 mth–2 yr
Brazil	1–5 yr	1–5 yr	1–5 yr
Canada ..	0–7 yr	0–7 yr	0–life
Chile	No penalty	5–20 yr	5–20 yr
Costa Rica ..	6 mth–1 yr	6 mth–1 yr	Mandatory 6 mth–3 yr
Cyprus ..	0–10 yr	0–10 yr	0–10 yr
Denmark ..	No penalty	0–2 yr	0–6 yr
Ecuador ..	Penalty not available	Penalty not available	4–8 yr
Finland ..	14 days–4 yr	14 days–4 yr	14 days–4 yr
Gabon ..	6 mth–2 yr	6 mth–2 yr	6 mth–2 yr
Ghana ..	0–10 yr	0–10 yr	0–10 yr
Guatemala ..	0–3 yr	0–3 yr	0–3 yr
Ivory Coast ..	3 mth–5 yr	3 mth–5 yr	3 mth–5 yr
Jordan ..	0–3 yr	0–3 yr	0–3 yr
Lebanon ..	0–6 mth	0–6 mth	6 mth–3 yr
Norway ..	0–2 yr	0–2 yr (simple) 0–6 yr (with intent)	0–6 yr
Peru	2–15 yr	2–15 yr	2–15 yr
Phillipines ..	0–5 yr	0–5 yr	0–5 yr
Senegal ..	3 mth–5 yr	3 mth–5 yr	3 mth–5 yr
Sweden ..	Minor offence: fine Offence: 0–2 yr Serious offence: 1–6 yr	Minor offence: fine Offence: 0–2 yr Serious offence: 1–6 yr	Minor offence: fine Offence: 0–2 yr Serious offence: 1–6 yr
Togo	3 mth–5 yr	3 mth–5 yr	3 mth–5 yr
Turkey ..	3–5 yr	Not less than 5 yr + 2–5 yr Banishment	Not less than 5 yr + 2–5 yr Banishment
United Kingdom	S 6 mth I 5 yr	S 1 yr I 14 yr	S 1 yr I 14 yr
Venezuela ..	4–8 yr	4–8 yr	4–8 yr
Yugo-Slavia ..	0–30 days	0–30 days	3 mth–5 yr

NOTE—S—summary offence; I—indicted offence.

APPENDIX VII

STUDY OF SENTENCING PATTERNS FOR DRUG OFFENCES IN NEW ZEALAND—1969 AND 1971

(a) Review of Sentences and Related Matters

Sponsorship and Methods

In their first report published in 1969 the Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand stated that it was planning to make a study of the sentences given by the courts for offences involving drugs (8.18) and, in November 1971, I was employed by the Department of Health as research assistant to the Committee on Drug Dependency and Drug Abuse. I undertook a survey of all drug cases heard in the five main centres: that is in the Supreme Courts of Auckland, Hamilton, Wellington, Christchurch, and Dunedin, in the Magistrates' Courts of North Shore, Takapuna, Central Auckland, Hamilton, Wellington, Lower Hutt, Christchurch, and Dunedin, and in the Children's Courts of Auckland, Hamilton, Wellington, Christchurch, and Dunedin during 1969 and 1971.

Court records are indexed only by name and not by offence and so I first made a preliminary list of names of individuals involved in narcotics seizures using the records of the Departments of Police, Customs, and Health. I then checked this list against the court records and found that some offenders were not charged, or were charged in years and courts not included in the survey. Court files were unobtainable in a small number of cases because of their constant movement as fines were paid, warrants issued for non-payment of fines, appeals brought, hearing dates set, and inquiries received from solicitors. In such cases I made use of police records and copies of probation reports.

After recording the data I developed coding categories and transcribed the information on to code sheets. I used "distinct individuals" as the unit of analysis and standardised age by taking 1 January as the date of birth. Where several charges were laid against one person, I used the charge incurring the heaviest penalty and made a distinction between previous convictions for drug offences and those for other offences. Strictly speaking, the Children's Court does not "convict" but "deals with" defendants. However, I have used "convictions" as a blanket term to include cases heard in the Children's Court.

The coded data was processed by the National Health Statistics Centre during April-October 1972. I returned to university, working occasionally on the data as it came to hand, and completed my analysis while employed by the Department of Health as a vacation worker in the Environmental Health Section between November 1972 and March 1973.

Legislation

The law provides that certain factors must be taken into account when dealing with offenders, and drug offenders are dealt with within this general framework. According to the Summary Proceedings Act 1958 a defendant has the right to elect trial by jury where the offence is punishable by more than 3 months' imprisonment, except for assault which, when charged under the Police Offences Act 1927, has a

maximum sentence of 6 months without giving a right of election. A magistrate may not impose a sentence greater than 3 years' imprisonment and/or a fine of $1,000, but he may decline jurisdiction or commit a defendant to a Supreme Court judge for sentencing. Charges involving defendants under 17 years of age are heard in the Children's Court and a child welfare officer must make a report.

The Criminal Justice Act 1954 provides that a person under 21 years may not be imprisoned "unless the Court, having regard to his character and personal history and to all the circumstances of the case has formed the opinion that he should be imprisoned notwithstanding his age". Sentences to borstal training, detention centre, and periodic detention may be imposed only where the offence is punishable by imprisonment, as alternatives to the latter, for instance in the cases of persons under 21 years. Sentence to borstal training may only be imposed on persons not less than 17 years and under 21 (although in certain circumstances persons 15 years and over may be sentenced to borstal training). Sentence to periodic detention may be imposed on persons not less than 15 years and sentence to a detention centre, which is always for 3 months, may be imposed on persons not less than 16 years. Probation must not exceed a period of 3 years and must not be less than 1 year. If a prison sentence of less than 1 year is imposed, probation of less than 1 year may be imposed.

The Narcotics Act 1965 states that the maximum penalty for offences of dealing (including importing, exporting, producing, selling, distributing, giving, administering, or offering to do so, possession for the purpose of dealing and cultivating) is 14 years and/or $2,000 fine. The offender must be imprisoned unless circumstances are such that the magistrate forms the opinion that he should not be. For possession and use of a narcotic, permitting premises or a vehicle to be used for commission of an offence against the Narcotics Act, possession of any needle, syringe, pipe, or other utensil for any such purpose, possession of the seed of a prohibited plant, or being on premises used for smoking opium, the maximum penalty is 3 months' imprisonment and/or a $400 fine. For offences of theft, false pretences, and receiving dishonestly obtained narcotics the maximum penalty is 7 years' imprisonment. The Poisons Act 1960 states that the maximum penalty for offences of dealing, forgery, and uttering is 6 months and/or a $1,000 fine, and for the offences of possession or use the maximum penalty is 3 months' imprisonment and/or a $400 fine. These are maximum sentences and are not mandatory.

Regional Variations

As might be expected, because of the uneven distribution of New Zealand's population, the cases tried were distributed unevenly between the centres where the courts are located. (Table 3 (a) and (b).) Auckland accounted for by far the highest proportion of convictions, increasing from 49 percent in 1969 to 59 percent in 1971, Wellington in second place decreased, perhaps only temporarily, from 38 percent in 1969 to 23 percent in 1971, while Christchurch, Dunedin, and Hamilton with very much smaller totals increased their proportions slightly over the same period. Auckland with its higher total of convictions showed least variability in its sentencing pattern between the 2 years with a rather higher proportion than average of both discharges

and lesser detention sentences and rather lower proportions of all other categories in both years. Wellington had a higher than average proportion of fines only sentences, and hospital referrals in both years, but a higher than average proportion of prison sentences in 1969 gave way to a much lower than average one in 1971. Christchurch and Dunedin both had exceptionally low proportions of discharges and high proportions of prison sentences in 1971, but the figures were so small that no reliable conclusion can be drawn.

Nationality

While some drug defendants were non-New Zealanders the overwhelming majority were New Zealanders. The proportion of non-New Zealanders to New Zealanders indicates the extent to which the problems and patterns of drug use are home grown. In 1969, 81 (72 percent) of the defendants on drug charges were New Zealanders and 31 (28 percent) were non-New Zealanders. In 1971, 271 (76 percent) of the defendants on drug charges were New Zealanders and 97 (24 percent) were non-New Zealanders. In 1969 non-New Zealanders were sent to prison or to hospital in roughly the same proportions as were New Zealanders. In 1971, of the 17 defendants sent to hospital and the 38 defendants sent to prison, 3 (18 percent) and 7 (19 percent) were non-New Zealanders. In 1969 defendants from Great Britain totalled 16 (14 percent) and there were 3 from Australia, 3 from China, and 3 from the United States. In 1971 defendants from Great Britain totalled 49 (14 percent). Seventeen were from Australia and nine from the United States. Between 1969 and 1971 there was little change in the proportion of non-New Zealanders involved in drug offences.

Race

In the 2 years under consideration the proportion of New Zealand Maoris involved in drug offences is very much less than the proportion of New Zealand Maoris in the total population. In 1969 the only New Zealand Maori defendant was convicted of using cannabis and sentenced to prison, and the only Polynesian was hospitalised. The majority of the defendants were European (105) and 5 belonged to "other races". In 1971, 13 New Zealand Maoris (3.5 percent of the total defendants) were charged with drug offences and of these 3 were sent to hospital and 2 were imprisoned. The only Polynesian was placed on probation. The majority of the defendants were European (347) and a small number (7) belonged to "other races". As was the case with nationality, the racial distribution of defendants changed little between 1969 and 1971.

Occupations

Between 1969 and 1971 those in the health related services fell from 3.5 percent to 1.6 percent while those in the trade group rose from 2.7 percent to 7.6 percent. The proportion of clerical workers increased from 2 (1.8 percent) in 1969 to 24 (7 percent) in 1971. In 1969, in the student category, there were four secondary school students and seven university students (five studying social science and humanities, one science, and one not ascertainable). In 1971 there were 6 school students, 3 teachers' college students, 2 art and music

students, 1 technical student, and 30 university students (20 studying social sciences and humanities, 3 science and engineering, 3 commerce and law, 1 medicine, and 3 not ascertainable).

The information available on drug dependency, family background, marital status, and education is too limited in coverage to warrant tabulation or analysis in detail.

Drug Dependency

In 1969, 14 of those charged were identified in records and reports as drug dependants, all of whom were convicted. Five of those hospitalised and two of those imprisoned were from this group. There was also one identified as "psychologically dependent", one as "ex-dependent", and one as "possibly dependent". In 1971, 29 of those charged were identified as "drug dependants" and all were convicted. Twelve (75 percent) of those hospitalised and six (14 percent) of those imprisoned were from this group. There were also seven identified as "possibly dependent", six as "ex-dependent", and four as "psychologically dependent". Information was lacking in 53 cases in 1969 and 217 in 1971.

Family Background

Information on family background was recorded in 81 (22 percent) of the 368 cases tried in 1971.

Marital Status

Clear indication of marital status was given in only 81 of the 1971 cases, suggesting that the majority of the defendants were single. Of those known, 27 (7.5 percent) of the total defendants) were married, 26 (7.5 percent) were living in a *de facto* relationship and 10 (3 percent) were separated or divorced.

Education

In 1971 probation officers reported that 20 defendants had underdeveloped academic potential and 16 defendants combined high academic aims on their own or their parents' part with a poor academic capability or performance.

Travel

In 1971 information was available in 107 cases. Of these, 92 (25 percent of the total defendants) had travelled overseas; 32 (9 percent) had travelled to Australia and 27 (7.5 percent) elsewhere and 32 (9 percent) to New Zealand from overseas; 16 were seamen or ex-seamen.

Prosecutions and Committals on Non-drug Charges

In 1971 there were instances where a defendant on a non-drug charge was found to be involved with drugs:

(a) An ex-patient from Oakley unlawfully entered a motor van and when approached explained that he was high on barbituates.

(b) A girl shoplifted two dresses in order, she claimed, to sell them so that she might buy cannabis.

(c) A young man charged with theft and "being a rogue and a vagabond" appeared on television falsely claiming that he was withdrawing from barbiturates, that he had been in borstal, had stolen cars, and that he had mixed asthma pills with beer.
(d) A defendant on a burglary charge was alleged to hold cannabis parties and steal from his guests.
(e) A suspect in a burglary of a pharmacy was committed to a hospital because he was found to be suicidal.
(f) A defendant who stole a shaver admitted using drugs illegally.
(g) A Hamilton youth who unlawfully took a motorcar with the intention of driving to the Jerusalem commune was alleged to have mainlined opium.
(h) A man found unlawfully on a building site was found to be in a confused and elated state attributed to drugs.
(i) An application for committal to a hospital was made when a defendant went beserk after taking a prescription poison.
(j) A young man was charged with offensive behaviour after he wandered naked down a road under the influence of LSD, waving at passengers in cars.

Prosecutions Not Proceeded with in 1971

Prosecutions were not proceeded with in 3 instances where drug-taking led to hospitalisation, nor in a case where a patient on leave from Oakley Hospital "tipped" a taxi driver by bestowing on him 12 syringes and 2 ampoules of haloperidol. This patient's leave was cancelled. The reasons given in the police files for not proceeding were mainly insufficient evidence and the problem of *mens rea*. In general, very young persons coming under notice were only warned.

Remarks on Sentencing

The remarks made by magistrates give an indication of how some magistrates see the process of sentencing. In 1969 there were three cases where the magistrates' remarks were available. In each case the magistrate stressed the deterrent aspect of a sentence and in one case the magistrate mentioned the need to protect society from a grave social evil. In 1971 there were 10 cases where the magistrates' remarks were available. The need to protect society from the evil of drugs was mentioned six times and the deterrent aspect of a sentence was referred to four times. The importance of rehabilitating the defendant was referred to four times but in three cases deterrence and the need to protect society were stressed as more important. In addition individual magistrates also said that they drew a distinction between hard and soft drugs, between different forms of legally defined narcotics, for example, between cannabis and hashish, and between stealing drugs and using drugs. Individual magistrates also remarked that they usually dealt with first offenders by way of a fine, and that the courts were resorting to prison terms for those involved with drugs. Finally, one magistrate wished to publicise the fact that he would no longer tolerate counsel asking for leniency on the grounds that a conviction would ruin a defendant's career, because university students were not privileged but must obey the law: it was not the courts but their own actions which would ruin their careers.

Appeals

If an appeal is brought in the Supreme Court against a sentence imposed in the Magistrate's Court then the sentencing limits of three years and/or $1,000 fine still apply. In 1969 there were two appeals, both for the offence of cultivating cannabis. One defendant was found not guilty and the other had his sentence reduced from 3 years' imprisonment to 6 months plus a fine of $100. In 1971 there were 17 appeals, 2 of which were dismissed. In two cases the defendants were found not guilty and in four cases sentences to borstal training and imprisonment were altered to provide for committal under the Alcoholism and Drug Addiction Act. Two prison sentences of 6 months and 9 months were reduced to probation with special conditions and probation plus a $300 fine. A further two prison sentences of 21 months were reduced to 6 months' imprisonment plus a $1,000 fine and to 6 months' imprisonment. A sentence to borstal training and one to a detention centre were both altered to periodic detention. Finally, for an offence of selling, sentence was increased on appeal from 9 months' imprisonment to 2 years' imprisonment.

Decline of Jurisdiction

Jurisdiction was declined by a magistrate once in 1969 and the Supreme Court imposed a sentence of 3 years' imprisonment. Jurisdiction was declined twice in 1971 and the Supreme Court imposed sentences of 1 year and 3 years' imprisonment. In all these cases the sentences imposed by the Supreme Court were within magisterial limits.

Case Law

Precedents may only be set in the Supreme Court but points raised in both courts or the application and interpretation of the law play a part in constructing the general practice of common law. Some such points were raised in several of the cases covered by the survey. In 1969 there was a test case in Christchurch. The defendant, who had given some of his librium pills to a girl at his place of work because she was feeling upset and nervous, was discharged under section 42 with the warning that he was fortunate not to receive a stiff penalty. In Wellington a case was dismissed because the prosecution for "possession of a pipe for the purpose of using a narcotic" did not specify which of three pipes was referred to. In an Auckland case it was established that a prosecution for the supply of a narcotic based on the supply of cannabis seeds could not succeed. The question of *mens rea* or guilty knowledge was first raised in 1969 during an Auckland case involving the cultivation of cannabis. The judge decided that parliament had intended an absolute prohibition and that it was a crime to cultivate cannabis regardless of knowledge that the plant was prohibited. On appeal it was ruled that if a penal provision is reasonably capable of two interpretations then that most favourable to the accused must be adopted. The burden of proof as regards *mens rea* rests on the accused: that is, the defendant must prove lack of knowledge. In 1971 one point was raised during an appeal in Hamilton. The appeal was based on the interpretation given to the word "lysergide" as only one isomer is supposed to give an hallucinatory effect. Because the Narcotics Act covers all the isomers of prohibited drugs the appeal was dismissed.

Formal Background of the Researcher

It is unfortunate that in the social sciences, wholly value-free research is neither practicable nor attainable. Indeed, the first steps taken by the researcher involve the development of a survey sheet, the data and judgments for which are important. Even if such a value-free approach were attainable in a survey such as this, the rigidity involved would offset the benefits likely to accrue.

When I began this survey, I had just completed my B.A. honours degree in sociology, which included a criminology course. I have also studied political science, Maori studies, philosophy, and English at university.

In my personal view of life—the world, man, and the direction in which mankind is heading—I am influenced by the synthesis developed by Pére Teilhard de Chardin, whose concept of the world around us, its origins, and its prospects, give due weight to the past, to the present, to values and to potentials.

When I was commissioned to undertake this survey, I was not aware of holding any strong ideas or viewpoints about misusers of drugs, even though I did have some expectations about what I might find. I expected all "addicts" to be committed to hospital for treatment, and all "traffickers" to be imprisoned. I also expected the "form of use" to be an important distinction—as to whether it is intravenous, non-intravenous—but found, in fact, that this distinction was overshadowed by the distinctions between the known and reputed powers of different drugs. The "form of use" is interwoven with the kind of drug used. I visualised drugs and offences as being on scales of graduated, if not fully defined, harmfulness, and also assumed at the beginning a fairly close inter-relationship between these notional scales. When I examined the overall records, I soon recognised that my expectations did not correspond very closely with what I found to be the case. I was surprised to find that some prescription poisons are potentially as addictive as some so-called "hard" drugs. I also found that many of those who misused drugs, at some time or another were themselves at least technically at risk of a charge of "dealing", as defined under the Act.

In the course of my research, I came to appreciate very clearly that any attempt to place drug misusers into hard and fast categories involves errors in judgment and fallacious reasoning. I found drug misusers to be very much individuals, although they may well have qualities, attitudes, outlooks, and problems in common with other misusers, as well as with the non-involved members of the community. Although some factors may be constant for a period, the needs and attitudes of drug misusers are constantly changing.

The courts clearly recognised the individuality of the defendants, and endeavoured to take this into account when sentencing. I was agreeably surprised at the large proportion of cases in which probation, medical, and other reports were sought prior to determining the case, and the extent to which the court's decision was influenced by the history and recommendations given in such reports.

MARGARET K. GEDDES.

1 May 1973.

(b) **Drug Offences in New Zealand: Study of Sentencing Patterns**

Table 1—Cases Tried, by Courts and Court Location, 1969 and 1971

	Auckland	Wellington	Christchurch	Dunedin	Hamilton	Total
1969—						
Children's Court ..	5	1	..	..	..	6
Magistrate's Court ..	49	40	11	1	1	102
Supreme Court ..	4	..	..	..	..	4
N.S.	..	..	..	..	..	..
Total cases 1969 ..	58	41	11	1	1	112
1971—						
Children's Court ..	2	..	4	..	..	6
Magistrate's Court ..	206	85	29	15	10	345
Supreme Court ..	4	5	3	2	3	17
N.S.	..	..	..	..	..	..
Total cases 1971 ..	212	90	36	17	13	368

Table 2—Cases Tried, by Age Groups, Court and Sex, 1969 and 1971

	Children's Court		Magistrate's Court		Supreme Court		Total All Courts		
	M	F	M	F	M	F	M	F	Total
1969—									
15–19 years	1	5	20	10	..	..	21	15	36
20–24	..	..	44	3	1	1	45	4	49
25–29	..	..	9	3	1	1	10	4	14
30–34	..	..	4	..	..	..	4	..	4
35–39	..	..	3	1	..	..	3	1	4
40–44	..	..	1	..	..	..	1	..	1
45–49	..	..	3	..	..	..	3	..	3
50–54	..	..	1	..	..	..	1	..	1
55–59	..	..	..	..	..	..	..	..	..
60–64	..	..	..	..	..	..	..	..	..
65 years and over ..	..	..	..	..	..	..	..	..	..
Total cases 1969	1	5	85	17	2	2	88	24	112
1971—									
15–19 years	3	2	74	26	..	1	77	29	106
20–24	..	1	150	32	4	3	154	36	190
25–29	..	..	30	11	4	..	34	11	45
30–34	..	..	8	..	2	1	10	1	11
35–39	..	..	4	6	2	..	6	6	12
40–44	..	..	1	..	..	..	1	..	1
45–49	..	..	..	..	..	..	..	..	..
50–54	..	..	1	1	..	..	1	1	2
55–59	..	..	..	..	..	..	..	..	..
60–64	..	..	..	..	..	..	..	..	..
65 years and over ..	..	..	..	..	1	..	1	..	1
Total cases 1971	3	3	268	76	13	5	284	84	368

Table 3 (a)—Sentences by Court and Court Location 1969

1969	Auckland	Wellington	Christchurch	Dunedin	Hamilton	Total
A. Convicted and discharged	7	4	2	..	..	13
B. Fines only	17	16	4	..	..	37
C. Probation with or without small fine	8	7	4	..	1	20
D. Large fine and probation	4	2	..	..	..	6
E. Periodic detention	1	..	..	..	..	1
F. Detention centre	4	..	..	..	..	4
G. Borstal	2	..	..	..	..	2
H. Prison—						
1 month	..	..	..	..	..	0
2 months	1	..	..	..	..	1
3 months	..	1	..	..	..	1
I. Prison—						
3–12 months	..	2	..	1	..	3
1–3 years	1	2	..	..	..	3
3+ years	..	..	..	..	..	..
J. Hospital—						
ADA Act	..	3	1	..	..	4
Returned to hospital	2	..	..	..	..	2
Discharge on voluntary admission	1	1	..	..	..	2
Plus borstal	..	..	..	..	..	..
K. Other	2	1	..	..	..	3
Total convictions	50	39	11	1	1	102
Withdrawn, acquitted, etc.	8	2	..	..	..	10
Total cases tried	58	41	11	1	1	112

Table 3 (b)—Sentences by Court and Court Location 1971

1971	Auckland	Wellington	Christchurch	Dunedin	Hamilton	Total
A. Convicted and discharged	26	3	1	1	1	32
B. Fines only	67	36	5	5	2	115
C. Probation with or without small fine	32	22	11	..	1	66
D. Large fine and probation	10	5	8	..	..	23
E. Periodic detention	9	1	1	..	1	12
F. Detention centre	10	..	..	..	1	11
G. Borstal	6	..	1	..	..	7
H. Prison—						
1 month	2	..	..	1	..	3
2 months	3	..	..	..	..	3
3 months	5	..	..	..	..	5
I. Prison—						
3–12 months	3	3	5	2	..	13
1–3 years	7	2	2	2	1	14
3+ years	1	..	..	1	1	3
J. Hospital—						
ADA Act	4	3	1	2	..	10
Returned to hospital	1	1	..	..	..	2
Discharge on voluntary admission	3	1	..	..	..	4
Plus borstal	..	..	..	..	1	1
K. Other	6	2	..	1	..	9
Total convictions	195	79	35	15	9	333
Withdrawn, acquitted, etc.	17	11	1	2	4	35
Total cases tried	212	90	36	17	13	368

Table 4 (a)—Sentences by Court, Age Groups, and Sex, 1969

1969	15–19 Years	20–24 Years	25–29 Years	30–49 Years	50 Years and Over	M	F	Total
A. Convicted and discharged	4	5	3	..	1	6	7	13
B. Fines only	5	19	6	7	..	34	3	37
C. Probation with or without small fine	11	6	3	..	..	12	8	20
D. Large fine and probation	3	3	..	..	..	5	1	6
E. Periodic detention	1	..	..	..	..	1	..	1
F. Detention centre	3	1	..	..	..	4	..	4
G. Borstal	2	..	..	..	..	2	..	2
H. Prison—								
1 month	..	..	..	..	..	..	..	..
2 months	..	1	..	..	..	1	..	1
3 months	..	..	..	1	..	1	..	1
I. Prison—								
3–12 months	1	1	..	1	..	3	..	3
1–3 years	..	3	..	..	..	3	..	3
3+ years	..	..	..	..	..	..	..	..
J. Hospital—								
ADA Act	..	3	..	1	..	4	..	4
Returned to hospital	1	1	..	..	..	1	1	2
Discharged on voluntary admission	1	1	..	..	..	1	1	2
Plus borstal	..	..	..	..	..	..	..	..
K. Other	..	2	..	1	..	3	..	3
Total convictions	32	46	12	11	1	81	21	102
Withdrawn, acquitted, etc. ..	4	3	2	1	..	7	3	10
Total cases tried	36	49	14	12	1	88	24	112

Table 4 (b)—Sentences by Court, Age Groups, and Sex, 1971

1971	15–19 Years	20–24 Years	25–29 Years	30–49 Years	50 and Over	M	F	Total
A. Convicted and discharged	14	14	1	2	1	20	12	32
B. Fines only	23	58	24	10	..	91	24	115
C. Probation with or without small fine	35	26	3	1	1	47	19	66
D. Large fine and probation	4	17	2	..	..	17	6	23
E. Periodic detention	4	7	1	..	..	12	..	12
F. Detention centre	5	6	..	..	..	11	..	11
G. Borstal	4	3	..	..	..	6	1	7
H. Prison—								
1 month		1	1	1	..	2	1	3
2 months		3	..	..	..	3	..	3
3 months		3	2	..	..	4	1	5
I. Prison—								
3–12 months		11	1	1	..	11	2	13
1–3 years		9	3	1	1	13	1	14
3+ years		1	2	..	..	3	..	3
J. Hospital—								
ADA Act	1	5	3	1	..	8	2	10
Returned to hospital	1	1	..	..	..	..	2	2
Discharged on voluntary admission	1	3	..	..	..	4	..	4
Plus borstal	1	..	..	..	..	1	..	1
K. Other	3	3	..	3	..	6	3	9
Total convictions	96	171	43	20	3	259	74	333
Withdrawn, acquitted, etc. ..	10	19	2	4	..	25	10	35
Total cases tried	106	190	45	24	3	284	84	368

Table 5—Sentences by Type of Offence, 1969 and 1971

	1969				1971			
	"Dealing"	Possession or Use	Other	Total	"Dealing"	Possession or Use	Other	Total
A. Convicted and discharged	1	11	1	13	5	27	..	32
B. Fines only	6	31	..	37	13	96	6	115
C. Probation with or without small fine	3	17	..	20	5	58	3	66
D. Large fine and probation	2	4	..	6	8	14	1	23
E. Periodic detention	1	..	..	1	3	9	..	12
F. Detention centre	..	4	..	4	3	8	..	11
G. Borstal	..	2	..	2	1	6	..	7
H. Prison—								
1 month	..	..	..	..	1	2	..	3
2 months	..	1	..	1	..	3	..	3
3 months	..	1	..	1	3	2	..	5
I. Prison—								
3–12 months	3	..	..	3	11	..	2	13
1–3 years	3	..	..	3	9	1	4	14
3+ years	..	..	..	..	3	..	..	3
J. Hospital—								
ADA Act	1	3	..	4	2	7	1	10
Returned to hospital	1	..	1	2	..	2	..	2
Discharged on voluntary admission	..	2	..	2	..	4	..	4
Plus borstal	..	..	..	..	1	..	..	1
K. Other	1	2	..	3	2	7	..	9
Total convictions	22	78	2	102	70	246	17	333
Withdrawn, acquitted, etc.	2	8	..	10	11	24	..	35
Total cases tried	24	86	2	112	81	270	17	368

Table 6 (a)—Convictions by Type of Drug—Court and Court Location, 1969

1969	Auckland	Wellington	Christ-church	Dunedin	Hamilton	Total Convictions	With-drawn Acquitted	Total Cases
Cannabis—								
Cannabis herb	16	15	..	1	1	33	3	36
Cannabis resin	..	..	1	..	..	1	..	1
Opioids—								
Opium	2	3	2	..	..	7	..	7
Heroin	..	..	..	..	..	..	..	..
Morphine salts	..	5	1	..	..	6	..	6
Methadone, pethidine	8	4	..	..	..	12	2	14
CS—								
LSD	..	..	..	..	..	..	..	..
Cocaine	..	1	..	..	..	1	..	1
Central stimulants	7	2	4	..	..	13	1	14
BHT—								
Barbiturates	6	..	..	..	..	6	3	9
Hypnotics	1	..	1	..	..	2	..	2
Tranquillisers	..	2	1	..	..	3	..	3
Mixed—								
Cannabis and other	..	1	1	..	..	2	..	2
Opioids and other	1	1	..	..	..	2	..	2
Other mixed	8	4	..	..	..	12	..	12
Miscellaneous	1	1	..	..	..	2	1	3
Total convictions	50	39	11	1	1	102	10	112

Table 6 (b)—Convictions by Type of Drug—Court and Court Location, 1971

1969	Auckland	Wellington	Christchurch	Dunedin	Hamilton	Total Convictions	Withdrawn Acquitted	Total Cases
Cannabis—								
Cannabis herb	66	32	15	6	2	121	15	136
Cannabis resin	20	7	3	1	..	31	1	32
Opioids—								
Opium	19	9	5	..	..	33	1	34
Heroin	2	..	1	..	..	3	..	3
Morphine salts	3	..	1	2	..	6	..	6
Methadone, pethidine	10	..	..	1	..	11	..	11
CS—								
LSD	17	14	1	3	4	39	9	48
Cocaine	..	..	..	..	..	..	..	..
Central stimulants	13	9	3	..	..	25	3	28
BHT—								
Barbiturates	4	..	1	..	..	5	..	5
Hypnotics	4	..	..	..	..	4	..	4
Tranquillisers	8	..	2	..	..	10	2	12
Mixed—								
Cannabis and Others	7	4	..	..	2	13	1	14
Opioids and Others	1	1	..	..	..	2	..	2
Other Mixed	14	1	..	2	1	18	1	19
Miscellaneous	7	2	3	..	..	12	2	14
Total convictions	195	79	35	15	9	333	35	368

Table 7 (a)—Offences of "Dealing", by Sentence, and Drug Named in Charge, 1969

1969	Cannabis		Opioids	LSD	CS	BHT	Mixed	Miscellaneous	Total "Dealing" Offences
	Herb	Resin							
A. Convicted and discharged ..	1	..	..	..	..	..	..	..	1
B. Fines only	2	..	..	..	1	2	1	..	6
C. Probation with or without small fine	1	..	..	..	..	1	1	..	3
D. Large fine and probation	..	..	2	..	..	..	..	..	2
E. Periodic detention	1	..	..	..	..	..	..	..	1
F. Detention centre	..	..	..	..	..	..	..	..	..
G. Borstal	..	..	..	..	..	..	..	..	..
H. Prison—									
1 month	..	..	..	..	..	..	..	..	..
2 months	..	..	..	..	..	..	..	..	..
3 months	..	..	..	..	..	..	..	..	..
I. Prison—									
3–12 months	1	..	2	..	..	..	..	..	3
1–3 years	1	..	2	..	..	..	..	..	3
3+ years	..	..	..	..	..	..	..	..	..
J. Hospital—									
ADA Act	..	..	..	..	..	..	1	..	1
Returned to hospital	..	..	..	..	..	1	..	..	1
Discharged on voluntary admission	..	..	..	..	..	..	..	..	..
Plus borstal	..	..	..	..	..	..	..	..	..
K. Other	..	..	..	..	..	..	1	..	1
Total convictions ..	7	0	6	0	1	4	4	0	22
Withdrawn, acquitted ..	2	..	..	..	..	..	..	..	2
Total cases tried	9	0	6	0	1	4	4	0	24

Table 7 (b)—Offences of Possession or Use, by Sentences, and Drug Named in Charge, 1969

1969	Cannabis		Opioids	LSD	CS	BHT	Mixed	Miscellaneous	Total	"Other" Offences
	Herb	Resin								
A. Convicted and discharged ..	2	..	2	..	3	2	1	1	11	1
B. Fines only	14	..	5	..	7	1	4	..	31	..
C. Probation with or without small fine	6	1	4	..	3	2	1	..	17	..
D. Large fine and probation ..	1	..	3	..	..	..	..	..	4	..
E. Periodic detention	..	..	1	..	..	..	..	..	1	..
F. Detention centre	..	..	1	..	..	..	3	..	4	..
G. Borstal	..	..	2	..	..	..	..	..	2	..
H. Prison—										
1 month	..	..	..	..	..	..	..	..	..	..
2 months	1	..	..	..	..	..	..	..	1	..
3 months	1	..	..	..	..	..	..	..	1	..
I. Prison—										
3–12 months	..	..	..	..	..	..	..	..	..	..
1–3 years	..	..	..	..	..	..	..	..	..	..
3+ years	..	..	..	..	..	..	..	..	..	..
J. Hospital—										
ADA Act	1	..	1	..	1	..	..	..	3	..
Returned to hospital	..	..	..	..	..	..	..	..	..	1
Discharged on voluntary admission	..	..	1	..	..	1	..	..	2	..
Plus borstal	..	..	..	..	..	..	..	..	..	..
K. Other	..	..	..	..	..	..	1	..	1	..
Total convictions	26	1	20	..	14	6	10	1	78	2
Withdrawn, acquitted ..	1	..	2	..	1	3	..	1	8	..
Total cases tried	27	1	22	..	15	9	10	2	86	2

Table 7 (c)—Offences of "Dealing", by Sentences, and Drug Named in Charge, 1971

1971	Cannabis		Opioids	LSD	CS	BHT	Mixed	Miscellaneous	Total "Dealing" Offences
	Herb	Resin							
A. Convicted and discharged ..	3	..	..	..	2	..	..	..	5
B. Fines only	11	..	..	..	1	..	1	..	13
C. Probation with or without small fine	1	..	..	2	..	..	1	1	5
D. Large fine and probation ..	4	1	1	2	..	..	..	..	8
E. Periodic detention	2	..	..	..	1	..	..	..	3
F. Detention centre	2	..	..	..	..	..	..	1	3
G. Borstal	..	1	..	..	..	..	..	..	1
H. Prison—									
1 month	..	1	..	..	..	..	..	..	1
2 months	..	..	..	..	..	..	..	..	..
3 months	2	..	1	..	..	..	..	..	3
I. Prison—									
3–12 months	7	..	..	3	..	..	1	..	11
1–3 years	1	1	4	1	..	..	2	..	9
3+ years..	..	..	..	3	..	..	..	..	3
J. Hospital—									
ADA Act	..	..	..	1	..	..	1	..	2
Returned to hospital ..	..	..	..	..	..	..	..	..	..
Discharged on voluntary admission	..	..	..	..	..	..	..	..	..
Plus borstal	..	..	..	..	..	..	1	..	1
K. Other	2	..	..	..	..	..	..	..	2
Total convictions ..	35	4	6	12	4	..	7	2	70
Withdrawn, acquitted ..	7	..	..	3	..	..	1	..	11
Total cases tried	42	4	6	15	4	..	8	2	81

Table 7 (d)—Offences of Possession or Use, by Sentences, and Drug Named in Charge, 1971

1971	Cannabis		Opioids	LSD	CS	BHT	Mixed	Miscellaneous	Total Possession or Use	Total Other Offences
	Herb	Resin								
A. Convicted and discharged ..	4	2	5	7	1	5	3	..	27	..
B. Fines only	48	14	3	10	9	3	5	4	96	6
C. Probation with or without small fine	20	7	12	5	4	4	4	2	58	3
D. Large fine and probation ..	3	1	3	2	1	1	3	..	14	1
E. Periodic detention	5	1	1	1	..	1	..	..	9	..
F. Detention centre	..	1	4	1	..	2	..	..	8	..
G. Borstal	..	..	4	..	..	..	2	..	6	..
H. Prison—										
1 month	1	..	..	1	..	..	..	..	2	..
2 months	1	1	1	..	..	..	..	..	3	..
3 months	1	..	..	..	..	..	1	..	2	..
I. Prison—										
3–12 months	..	..	..	..	..	..	..	..	..	2
1–3 years	..	..	..	..	..	..	..	1	1	4
3+ years	..	..	..	..	..	..	..	..	..	..
J. Hospital—										
ADA Act	..	..	5	..	1	1	..	..	7	1
Returned to hospital	..	..	..	..	..	..	2	..	2	..
Discharged on voluntary admission	..	..	3	..	..	..	1	..	4	..
Plus borstal	..	..	..	..	..	..	..	..	..	..
K. Other	2	..	2	..	1	..	2	..	7	..
Total convictions	85	27	43	27	17	17	23	7	246	17
Withdrawn, acquitted ..	8	1	1	6	3	2	1	2	24	..
Total cases tried	93	28	44	33	20	19	24	9	270	17

Table 8 (a)—Sentences by Drug Offence Record, 1969

1969	Not known	First Drug Offence	Second Drug Offence	Third Drug Offence	More than Third Drug Offence	Not First but Number Unknown	Total
A. Convicted and discharged ..	3	7	1	..	1	1	13
B. Fines only	5	28	1	2	..	1	37
C. Probation with or without small fine	5	11	3	1	..	..	20
D. Large fine and probation ..	..	5	1	..	..	..	6
E. Periodic detention	..	1	..	..	..	..	1
F. Detention centre	..	4	..	..	..	..	4
G. Borstal	..	2	..	..	..	..	2
H. Prison—							
1 month	..	..	..	..	..	..	..
2 months	..	1	..	..	..	..	1
3 months	..	1	..	..	..	..	1
I. Prison—							
3–12 months	..	2	1	..	..	..	3
1–3 years	1	1	..	..	..	1	3
3+years	..	..	..	..	..	..	
J. Hospital—							
ADA Act	..	1	..	..	3	..	4
Returned to hospital	1	1	..	..	..	..	2
Discharged on voluntary admission	..	1	..	..	1	..	2
Plus borstal	..	..	..	..	..	..	
K. Other	..	2	..	..	..	1	3
Total convictions	15	68	7	3	5	4	102
Withdrawn, acquitted, etc. ..	5	5	..	..	..	..	10
Total cases tried	20	73	7	3	5	4	112

Table 8 (b)—Sentences by Drug Offence Record 1971

1971	Not known	First Drug Offence	Second Drug Offence	Third Drug Offence	More than Third Drug Offence	Not First but Number Unknown	Total
A. Convicted and discharged ..	7	21	2	..	1	1	32
B. Fines only	12	94	6	3	..	..	115
C. Probation with or without small fine	1	60	4	..	1	..	66
D. Large fine and probation	..	22	1	..	..	..	23
E. Periodic detention	2	7	1	2	..	..	12
F. Detention centre	..	8	3	..	..	..	11
G. Borstal	..	4	2	1	..	..	7
H. Prison—							
1 month	1	2	..	..	..	..	3
2 months	..	1	2	..	..	..	3
3 months	..	2	2	..	1	..	5
I. Prison—							
3–12 months	1	9	1	..	1	1	13
1–3 years	..	8	3	1	2	..	14
3+ years	..	2		..	..	..	3

J. Hospital—								
ADA Act	4	2	4	..	..	..	10
Returned to hospital	..	1	1	..	..	..	2
Discharged on voluntary admission	1	1	2	..	..	..	4
Plus borstal	1	..	..	..	..	..	1
K. Other	4	5	..	..	..	..	9
Total convictions	34	249	35	7	6	2	333
Withdrawn, acquitted, etc. ..	14	18	1	1	1	..	35
Total cases tried	48	267	36	8	7	2	368

Table 9 (a)—Sentences by Associated Offences 1969

1969	1 None or Not Known	4 Drug Offence	5 Theft, Larceny, Receiving	6 Robery, Burglary	2 Idle or Disorderly Not Under Control	7 Resisting Arrest, Obstruction	8 Breach of Probation	9 Credit by Fraud	3 Minor Other	10 Major Other	Total
A. Convicted and discharged	11	..	2	..	..	..	..	..	..	..	13
B. Fines only	29	6	2	..	..	..	..	..	..	..	37
C. Probation with or without a small fine ..	11	4	1	1	2	..	..	..	1	..	20
D. Large fine and probation	5	..	..	..	..	1	..	..	..	..	6
E. Periodic detention ..	1	..	..	..	..	..	..	..	..	..	1
F. Detention centre ..	2	1	1	..	..	..	..	..	..	..	4
G. Borstal	2	..	..	..	..	..	..	..	..	..	2
H. Prison—											
1 month	..	..	..	..	..	..	..	..	..	..	..
2 months	1	..	..	..	..	..	..	..	..	..	1
3 months	..	..	..	1	..	..	..	..	..	..	1
I. Prison—											
3–12 months		3	..	..	..	..	..	..	..	..	3
1–3 years	2	..	..	1	..	..	..	..	..	..	3
3 + years	..	..	..	..	..	..	..	..	..	..	..

J. Hospital—											
ADA Act ..	1	..	1	2	..	..	..	..	..	..	4
Returned to hospital	2	..	..	..	..	..	..	..	..	..	2
Discharged on voluntary admission ..	1	..	..	..	..	..	..	..	..	1	2
Plus borstal ..	..	..	..	..	..	..	..	..	..	..	..
K. Other	2	1	..	..	..	..	..	..	..	..	3
Total convictions ..	70	15	7	5	2	1	..	..	1	1	102
Withdrawn, acquitted	9	1	..	..	..	..	..	..	..	..	10
Total cases tried ..	79	16	7	5	2	1	..	..	1	1	112

Table 9 (b)—Sentences by Associated Offences 1971

1971	1 None or Not Known	2 Drug Offence	5 Theft, Larceny, Receiving	6 Robbery, Burglary	3 Idle or Disorderly	7 Resisting Arrest, Obstruction	8 Breach of Probation	9 Credit by Fraud	4 Minor Other	10 Major Other	Total
A. Convicted and discharged	31	..	..	1	..	..	..	..	..	..	32
B. Fines only	83	24	2	2	2	1	..	..	..	1	115
C. Probation with or without small fine ..	53	9	3	..	..	..	..	..	1	..	66
D. Large fine with probation	14	9	..	..	..	..	..	..	..	..	23
E. Periodic detention ..	8	3	..	..	..	..	1	..	..	..	12
F. Detention centre ..	8	1	..	1	..	..	1	..	..	..	11
G. Borstal	3	2	..	2	..	..	..	..	..	..	7
H. Prison—											
1 month	2	..	..	..	..	..	..	..	..	1	3
2 months	3	..	..	..	..	..	..	..	..	..	3
3 months	4	1	..	..	..	..	..	..	..	..	5
I. Prison—											
3–12 months ..	8	3	1	1	..	..	..	..	..	..	13
1–3 years	7	5	1	1	..	..	..	..	..	..	14
3 + years	..	3	..	..	..	..	..	..	..	..	3

J. Hospital—											
ADA Act ..	5	1	1	2	..	..	1	..	..	..	10
Returned to hospital	..	1	1	..	..	..	..	..	..	..	2
Discharged on voluntary Admission ..	..	3	..	1	..	..	..	..	..	..	4
Plus borstal ..	1	..	..	..	..	..	..	..	..	..	1
K. Other	5	2	1	..	..	1	..	..	..	..	9
Total convictions ..	235	67	10	11	2	2	3	..	1	2	333
Withdrawn, acquitted	28	5	..	..	2	..	..	..	..	..	35
Total cases tried ..	263	72	10	11	4	2	3	..	1	2	368

Table 10 (a)—Sentences by Previous Non-drug Convictions, 1969

1969	1 Not Known or None	2 Minor Traffic	3 Minor*	4 Theft, Larceny, Taking Car or Bike	5 Major Traffic Offence, Resisting Arrest, Assault, Fighting, Wilful damage	6 Offensive Weapon, Firearm	7 False Pretences, Forgery, Fraud, Uttering	8 Burglary	9 Desertion from Ship, Stowaway	10 Neglecting Child, Rape, Other	Total
A. Convicted and discharged	9	..	2	..	..	..	..	2	..	..	13
B. Fines only	31	1	2	..	1	..	1	..	..	1	37
C. Probation with or without a small fine	10	..	3	2	3	..	..	2	..	..	20
D. Large fine and probation	2	..	1	1	..	..	..	2	..	..	6
E. Periodic detention ..	1	..	..	..	..	..	..	..	..	..	1
F. Detention centre ..	2	..	..	..	..	1	..	1	..	..	4
G. Borstal	..	..	..	1	..	..	..	1	..	..	2
H. Prison—											
1 month	..	..	..	..	..	..	..	..	..	..	..
2 months	1	..	..	..	..	..	..	..	..	..	1
3 months	..	..	..	..	..	..	..	1	..	..	1

I. Prison—												
3–12 months	..	2	..	..	1	..	..	..	..	..	..	3
1–3 years ..	..	2	..	..	..	..	..	..	1	..	..	3
3+ years ..	..	..	..	..	..	..	..	..	..	..	..	..
J. Hospital—												
ADA Act ..	..	..	..	..	..	1	..	1	2	..	..	4
Returned to hospital ..		..	..	..	2	..	..	..	..	..	..	2
Discharged on voluntary admission	..	1	..	..	1	..	..	..	..	..	..	2
Plus borstal ..	..	..	..	..	..	..	..	..	..	..	..	..
K. Other ..	..	2	..	..	1	..	..	..	..	..	..	3
Total convictions ..		63	1	8	9	5	1	2	12	..	1	102
Withdrawn, acquitted		8	..	2	..	..	..	..	..	..	..	10
Total cases tried ..		71	1	10	9	5	1	2	12	..	1	112

*Minor offences: not under control; on licensed premises under age; drunk . . .; obscene language; idle and disorderly.

Table 10 (b)—Sentences by Previous Non-drug Convictions, 1971

1971	1 Not Known or None	2 Minor Traffic	3 Minor*	4 Theft, Larceny, Taking Car or Bike	5 Major Traffic Offence, Resisting Arrest, Assault, Fighting, Wilful Damage	6 Offensive Weapon, Firearm	7 False Pretences Forgery, Fraud, Uttering	8 Burglary	9 Desertion from Ship, Stowaway	10 Neglecting Child, Rape, Other	Total
A. Convicted and discharged	28	..	1	..	1	..	..	2	..	..	32
B. Fines only	75	4	7	14	10	1	..	4	..	..	115
C. Probation with or without a small fine	42	2	6	8	3	..	..	4	..	1	66
D. Large fine and probation	17	1	1	1	2	..	..	1	..	..	23
E. Periodic detention ..	7	..	1	2	1	..	..	1	..	..	12
F. Detention centre ..	8	..	1	..	..	..	..	2	..	..	11
G. Borstal	2	..	1	2	..	..	..	2	..	..	7
H. Prison—											
1 month	1	..	..	..	..	..	..	..	2	..	3
2 months	2	..	..	..	1	..	..	..	..	..	3
3 months	3	..	..	1	..	..	..	1	..	..	5

I. Prison—											
3–12 months	11	..	..	1	..	..	..	1	..	..	13
1–3 years	4	..	3	3	1	..	1	2	..	..	14
3+ years	1	..	..	1	1	..	..	..	..	..	3
J. Hospital—											
ADA Act	7	..	..	..	..	..	..	3	..	..	10
Returned to hospital	1	..	..	..	..	..	..	..	1	..	2
Discharged on voluntary admission	3	..	..	1	..	..	..	..	..	..	4
Plus borstal	1	..	..	..	..	..	..	..	..	..	1
K. Other	7	..	..	..	2	..	..	..	..	..	9
Total convictions	220	7	21	34	22	1	1	23	3	1	333
Withdrawn, acquitted	28	..	1	3	1	..	..	..	2	..	35
Total cases tried	248	7	22	37	23	1	1	23	5	1	368

*Minor offences: not under control; on licensed premises under age; drunk . . .; obscene language; idle and disorderly.

APPENDIX VIII

INTERNATIONAL CONTROL OF NARCOTICS AND PSYCHOTROPIC SUBSTANCES

(a) United Nations Conference to Consider Amendments to the Single Convention on Narcotic Drugs 1961. Resolutions II and III adopted by the Conference

Resolution II

ASSISTANCE IN NARCOTICS CONTROL

The Conference,

Recalling that assistance to developing countries is a concrete manifestation of the will of the international community to honour the commitment contained in the United Nations Charter to promote the social and economic progress of all peoples,

Recalling the special arrangements made by the United Nations General Assembly under its resolution 1395 (XIV) with a view to the provision of technical assistance for drug abuse control,

Welcoming the establishment pursuant to United Nations General Assembly resolution 2719 (XXV), of a United Nations Fund for Drug Abuse Control,

Noting that the Conference has adopted a new article 14 *bis* concerning technical and financial assistance to promote more effective execution of the provisions of the Single Convention on Narcotics Drugs, 1961,

1. Declares that, to be more effective, the measures taken against drug abuse must be co-ordinated and universal;

2. Declares further that the fulfilment by the developing countries of their obligations under the Convention will be facilitated by adequate technical and financial assistance from the international community.

Resolution III

SOCIAL CONDITIONS AND PROTECTION AGAINST DRUG ADDICTION

The Conference,

Recalling that the Preamble to the Single Convention on Narcotic Drugs, 1961, states that the Parties to the Convention are "concerned with the health and welfare of mankind" and are "conscious of their duty to prevent and combat" the evil of drug addiction.

Considering that the discussions at the Conference have given evidence of the desire to take effective steps to prevent drug addiction,

Considering that, while drug addiction leads to personal degradation and social disruption, it happens very often that the deplorable social and economic conditions in which certain individuals and certain groups are living predispose them to drug addiction,

Recognizing that social factors have a certain and sometimes preponderant influence on the behaviour of individuals and groups,

Recommends that the Parties:

1. Should bear in mind that drug addiction is often the result of an unwholesome social atmosphere in which those who are most exposed to the danger of drug abuse live;

2. Should do everything in their power to combat the spread of the illicit use of drugs;

3. Should develop leisure and other activities conducive to the sound physical and psychological health of young people.

(b) Notes on Convention on Psychotropic Substances

In early 1971 a United Nations Conference was called to provide an instrument under which member countries would undertake to impose effective national control, and to co-operate in effective international control, of psychotropic substances. This term is employed to group together the hallucinogens such as LSD and mescaline; the central nervous system stimulants such as the amphetamine group and drugs of similar effect commonly called "pep pills"; and the central nervous system depressants, including the barbiturates, sleeping pills of similar pharmacological effect, and many of the so-called tranquillisers.

Problems related to the non-medical use of, dependence on, and illicit trafficking in these drugs had become of rapidly increasing concern in many countries. This was compounded by the appearance on the market of new and more potent drugs in this general category of psychotropic substances, some of which which had limited medical use, some of extensive medical use, but all with dangers of misuse and abuse. Accordingly, with the support of the World Health Assembly and the authority of the Economic and Social Council of the United Nations, the Commission on Narcotic Drugs drew up for consideration a proposed Protocol on Psychotropic Substances which was circulated to states for comment. This was the basis for discussion at the conference, on what was to be named later the Convention on Psychotrophic Substances.

In the preamble to the Convention, the Conference noted with concern the public health and social problems resulting from the abuse of certain psychotropic substances and the illicit traffic to which it gave rise, and expressed its opinion that vigorous measures were necessary to restrict the use of such substances for legitimate purposes. At the same time it recognised that the use of psychotropic substances for medical and scientific purposes was indispensable and that their availability for such purposes should not be unduly restricted. All 74 participants at the Conference voted for continued control of cannabis under the Single Convention on Narcotic Drugs 1961.

The Conference decided to list 32 substances in four schedules annexed to the Convention. (Appendix I.) As a result parties are required to place stringent limitations on the use of substances in Schedule I, and to restrict by such measures as are considered appropriate, the production, manufacture, export, import, distribution and stocks of, trade in, and use and possession of substances in Schedules II, III, and IV to medical and scientific purposes. The most rigorous measures of control are provided for those substances listed in Schedule I; LSD and mescaline, for example, are controlled in a more

stringent way than morphine under the narcotics treaties. The use of these substances must be prohibited except for scientific and very limited medical purposes by duly authorised persons, in approved medical and scientific establishments.

The manufacture of, trade in, and distribution of substances listed in Schedules II, III, and IV must be under licence or other similar control measures, and control must be exercised over all duly authorised persons and enterprises engaged in related activities. These substances may be supplied or dispensed for use by individuals pursuant to medical prescription only, and such prescriptions must be issued in accordance with sound medical practice.

Retail packages of psychotropic substances are required to carry appropriate warnings on labels and any accompanying leaflets; and the advertising of such substances to the general public must be prohibited.

Producers, manufacturers, retail distributors, institutions for hospitalisastion and care, and scientific institutions must keep records of produced and used psychotropic substances.

The Convention requires that every signatory country permitting the export or import of substances in Schedules I or II must issue a separate import or export authorisation on a form to be established by the Narcotic Commission, and for each such operation. Before issuing an export authorisation, exporting countries must receive an import authorisation, issued by the competent authority of the importing country. The government issuing the export authorisation must send a copy to the government of the importing country which, after importation has been effected, must return it, certifying the amount of substance actually imported. For export of substances in Schedule III exporters must furnish a declaration to the competent authorities of their country who, in their turn, must send, within 90 days, a copy to the competent authorities of the importing country.

The Secretary-General of United Nations is required to be furnished with such information as the Narcotics Commission may request as being necessary for the performance of its functions, and, in particular, an annual report report regarding the working of the Convention in each territory. Parties must also furnish, as soon as possible after the event, a report to the Secretary-General in respect of any case of illicit traffic in psychotropic substances or seizure from such illicit traffic which they consider important. Annual statistical reports in accordance with forms prepared by the International Narcotics Control Board must be furished by the competent authorities to the Board.

All practical measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, aftercare, rehabilitation, and social reintegration of the persons involved must be taken, and provision made to promote the training of personnel in this field, and the assistance of persons whose work so requires, to gain an understanding of the problems of abuse of psychotropic substances and of its prevention.

Most of the provisions of the Convention on Psychotropic Substances were already in force in New Zealand prior to the Conference, but additional controls to meet new treaty obligations either have been introduced, or will be introduced as soon as possible.

Lists of Substances in the Schedules*

List of Substances in Schedule I

	Inn	Other non-proprietary or Trivial Names	Chemical Name
1.		DET	N, N-diethyltryptamine
2.		DMHP	3-(1, 2-dimethylhepty1)-1-hydroxy-7, 8, 9, 10 tetrahydro-6, 6, 9-trimethyl-6H-dibenzo [b, 9] pyran
3.		DMT	N, N-dimethyltryptamine
4.	(+)-Lysergide ..	LSD, LSD-25	(+)-N, N-diethyllysergamide (d-lysergic acid diethylamide)
5.		mescaline	3, 4, 5-trimethoxyphenethylamine
6.		parahexyl	3-hexyl-1-hydroxy-7, 8, 9, 10- tetrahydro-6, 6, 9-trimethyl-6H- dibenzo [b, d] pyran
7.		psilocine, psilotsin	3-(2-dimethylaminoethyl)-4-hydroxyindole
8.	Psilocybine ..	..	3-(2-dimethylaminoethyl) indol-4-yl dihydrogen phosphate
9.		STP, DOM	2-amino-1-(2, 5-dimethoxy-4-methyl) phenyl-propane
10.		tetrahydrocannabinols, all isomers	1-hydroxy-3-pentyl-6a, 7, 10, 10a-tetrahydro-6, 6, 9-trimethyl-6-H-dibenzo [b, d] pyran

*The names printed in capitals in the left-hand column are the International Non-proprietary Names (INN). With one exception ((+)-lysergide), other non-proprietary or trival names are given only where no INN has yet been proposed.

List of Substances in Schedule II

1.	Amphetamine ..	..	(±)-2-amino-1-phenylpropane
2.	Dexamphentamine	..	(+)-2-amino-1-phenylpropane
3.	Methamphetamine	..	(+)-2-methylamino-1-phenylpropane
4.	Methylphenidate ..	..	2-phenyl-2-(2-piperidyl) acetic acid, methyl ester
5.	Phencyclidine ..	..	1-(1-phenylcyclohexyl) piperidine
6.	Phenmetrazine ..	..	3-methyl-2-phenylmorpholine

List of Substances in Schedule III

	Inn	Other non-proprietary or Trivial Names	Chemical name
1.	Amobarbital ..	..	5-ethyl-5-(3-methylbutyl) barbituric acid
2.	Cyclobarbital ..	..	5-(1-cyclohexen-1-yl)-5-ethylbarbituric acid
3.	Glutethimide ..	..	2-ethyl-2-methylamino-1-phenyl-propane
4.	Pentobarbital ..	..	5-ethyl-5-(1-methylbutyl) barbituric acid
5.	Secobarbital ..	..	5-allyl-5-(1-methylbutyl) barbituric acid

List of Substances in Schedule IV

Inn	Other non-proprictary or Trival Names	Chemical Name
1. Amfepramone ..	..	2-(diethylamino) propiophenone
2. Barbital	..	5, 5-diethylbarbituric acid
3.	ethchlorvynol	ethyl-2-chlorovinylethinylcarbinol
4. Ethinamate ..	..	1-ethynylcyclohexanolcarbamate
5. Meprobamate ..		2-methyl-2-propyl-1, 3-propanediol dicarbamate
6. Methaqualone ..	..	2-methyl-3-o-tolyl-4(3H)- quinazolinone
7. Methylphenobarbital	..	5-ethyl-1-methyl-5-phenyl- barbituric acid
8. Methyprylon ..	..	3, 3-diethyl-5-methyl-2, 4-piperidinedione
9. Phenobarbital ..	..	5-ethyl-5-phenylbarbituric acid
10. Pipradrol ..	..	1, 1-diphenyl-1-1-(2-piperidyl) methanol
11.	SPA	(-)-1-dimethylamine-1, 2-dipheny-lethane

(c) Notes on Protocol Amending the Single Convention on Narcotic Drugs 1961

As a result of a resolution by the Economic and Social Council of United Nations, a Conference was called in Geneva in 1972 to consider proposed amendments to the Convention on Narcotic Drugs 1961. New Zealand, a party to the Convention, was represented. At the end of its deliberations the Conference adopted and opened for signature a Protocol amending several articles of the Single Convention and introducing three new ones.

It was felt that the International Narcotics Control Board could render even more valuable services to the international community than hitherto if its membership were expanded to allow for a more varied geographical representation. The membership of the Board was increased accordingly by the Protocol from its present composition of 11 to 13 members. Moreover, in the Conference's view, the expertise required to fulfil satisfactorily the task entrusted to the members of the International Narcotics Control Board was such that the present term of three years was hardly sufficient to allow a new member to familiarise himself completely with the many aspects of the problem of international narcotic control and then apply his knowledge in the performance of his duties. The Protocol thus lengthened the term of office of members from 3 to 5 years. Furthermore, the Secretary of the Board will, in future, be appointed by the Secretary-General in consultation with the Board.

The Board's functions were, in part, redefined in an article of the Protocol, to emphasise the Board's objective of limiting the cultivation, production, manufacture, and use of drugs to an adequate amount required for medical and scientific purposes. This emphasis was also aimed at ensuring that all measures taken or recommended by the Board would be those most consistent with the intent to further the

co-operation of Governments with the Board. To this end, parties are required to supply additional data to the Board on the cultivation of the opium poppy and the manufacture of synthetic drugs.

In addition to the increased data to be made available to the International Narcotics Control Board by parties, the Board is now authorised to weigh information received from recognised sources such as a united national organ or a specialised agency, or other intergovernmental or international non-governmental organisation, which enjoys consultative status with the Economic and Social Council, provided that such source is approved by the Commission on Narcotic Drugs.

In case of a disagreement of estimates between a government and the Board, the latter is now authorised to publish and communicate its own estimates. In specific instances, the Board may also propose to a party that consultations be opened with a view to studying a particular local problem of drug addiction or illicit traffic.

Technical or financial assistance to a country engaged in combating such a local problem is the subject of a new article, to be included in the Single Convention. In the same general context, another new article provides for the establishment of regional centres for scientific research and diffusion of information to local populations on the dangers of drug addiction and the problems arising out of illicit traffic. These two new articles tie in with the amendments made to related articles of the Single Convention which stipulate that parties should furnish the INCB with all data they deem appropriate concerning illicit traffic within their borders, and that they should take all practical measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation, and social reintegration of persons involved, as well as promoting the training of personnel in the treatment, after-care rehabilitation, and social reintegration of abusers of drugs.

The Conference made no recommendation to alter the status of cannabis or the international controls for this substance now in force.

The Conference also amended an article of the Single Convention which has as its subject "Penal Provisions". As amended, this article provides that the parties may, either as an alternative or in addition to penal sanctions imposed for certain narcotic violations, oblige drug abusers to undergo measures of treatment, education, after-care, rehabilitation, and social reintegration. However, it retains the list of offences that was part of its unamended text. It continues to recommend imprisonment or other penalties of deprivation of liberty for serious offences in this list and now includes new subparagraphs dealing with extradition for such offences. Thus the offences listed in this amended article are deemed to be included as extraditable offences in any extradition treaty between parties; parties whose domestic law makes extradition conditional on the existence of a treaty may now elect to consider the amended Single Convention, as the legal basis for extradition in the absence of an extradition treaty between the requesting party and the requested party. Parties whose domestic law does not make extradition conditional on the existence of a treaty, are bound to recognise as between themselves, the offences listed in the amended article as extraditable offences.

New Zealand has reservations about the feasibility of amendments requiring that signatories furnish each year to the International Narcotics Control Board details relating to the cultivation of all opium poppy. It would be impossible to estimate the areas (or name their regions) wherein the opium poppy might be cultivated without a licence for purposes which are legitimate under the Narcotics Act 1965. In the terms of the Single Convention, "opium poppy" means the plant of the species *Papaver somniferum L.* There are other varieties within this species which are cultivated as decorative plants in New Zealand for the appearance of the flowers. There are other varieties which could be cultivated for the production of poppy seed (maw seed) which is used as a decoration and flavouring on breads and pastries. It would be impossible to furnish returns of areas and locations so cultivated to the opium poppy.

The Narcotics Act 1965 declares any plant of the species *Papaver somniferum L.* to be a prohibited plant, the cultivation of which without a licence is prohibited, but further providing that it shall be a defence for any person charged to prove that the plant cultivated was not intended to be a source of any narcotic and not being developed as a strain from which a narcotic could be produced. Estimates and statistics relating to licensed cultivation, of course, can and should be provided by New Zealand.

No difficulty is foreseen arising from any other article.

(d) Reporting on Working of International Treaties on Narcotic Drugs

The following extract from the report of the Government of New Zealand for the calendar year 1972 on the Working of the International Treaties on Narcotic Drugs in New Zealand, Niue, and the Tokelau Islands gives an indication of the scope of information requested and recorded in compliance of New Zealand's discharge of its responsibilities under the International Treaties relating to narcotic drugs. It categorically disposes of the widely disseminated and wholly erroneous belief that "addicts" are registered in New Zealand.

Abuse of Drugs (Drug Addiction)

Control and Treatment of all Habitual Users of Drugs Under International Control. (This does not cover persons misusing a wide range of dependency inducing drugs.)

(a) Addicts are not registered in New Zealand.

(b) Individual files are maintained on all cases of prolonged use or suspected addiction reported by medical practitioners or found by public health pharmacists and nurse inspectors in the course of their inspection duties. An expanded system to incorporate information at National Health Statistics Centre (hospital and psychiatric hospital admissions and discharges, and Registrar-General's causes of death returns) is at trial stage.

(c) Information sought for recording concerning addicts:

(i) Name, address, date of birth, and occupation.
(ii) Date when user first came to notice.
(iii) Aliases (if any used).
(iv) Source of information.
(v) Whether trafficker or recidivist.
(vi) Legal restraints imposed and date imposed.
(vii) Drug(s) used.
(viii) Form in which drug(s) used and manner of use.
(ix) Daily consumption.
(x) Frequency of consumption.
(xi) Drug(s) source.
(xii) Name of prescriber and supplier.
(xiii) Reason for initial use of drug(s).
(xiv) Duration of surveillance for licit supply.

(d) Records are maintained in the Department of Health.

(e) There is no system or requirement for the compulsory reporting of addicts. Cases may be uncovered by reports from:

(i) Medical practitioners.
(ii) Pharmacists.
(iii) Psychiatric hospitals.
(iv) Police.
(v) Inspection of pharmacy and hospital records by the Department's public health pharmacists.

Following which there is an investigation and assessment of the case and degree and source of addiction, if any, by the district medical officer of health.

(f) At 6-monthly periods the addict's medical attendant reports on his condition. Every attempt is made to persuade the addict to obtain hospital treatment for his condition. There is power to compel treatment but in some cases strongly persuasive pressure towards voluntary treatment may be brought to bear. There is power under the Narcotics Regulations to limit the addict to obtaining his supplies from one medical attendant and/or one pharmacy, or alternatively to prohibit him from obtaining any narcotic drug whatsoever from legitimate sources.

Records are retained for not less than 3 years after last-known access to narcotics or known death.

Reassessment at this time may result in retention of the records of possible reversionists indefinitely. The Alcoholism and Drug Addiction Act 1966 provides for either voluntary or compulsory committal of an addict to an appointed institution for a period of 2 years, subject to review every 6 months. While patients are still being accepted for treatment of addiction on a voluntary and informal basis in all psychiatric hospitals, patients committed under the Act are all admitted for treatment to Oakley Hospital, Auckland, which has opened a unit specifically for this purpose. A general medical practitioner, with one medical assistant but no laboratory or social work facilities or

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NOTE—The term "addiction" is a technical expression required for international reporting.

staff, has instituted an open private clinic for methadone substitution and limited group therapy. This is considered unsatisfactory and has attracted patients from less-permissive treatment regimes, and drug-free regimes, as well as previously unknown "patients". Steps are being taken to prohibit the supply of narcotics for the treatment of drug dependency by general medical practitioners. It is hoped to set up clinic facilities for this purpose in approved hospitals.

Several voluntary social organisations have instituted and are operating drug-free rehabilitation services of various types.

(e) Text of Letter from Secretary-General to Governments on United Nations Fund for Drug Abuse Control

Following is the text of a letter dated 26 March 1971 sent by the Secretary-General, U Thant, to all member governments of the United Nations regarding a United Nations Fund for Drug Abuse Control:

Sir,

"I have the honour to refer to General Assembly resolution 2719 (XXV) and Economic and Social Council resolution 1559 (XLIX), together with the report of the Commission on Narcotic Drugs on its second special session (E/4931) which requested the Secretary-General to establish, as an initial measure and as a matter of urgency, a United Nations Fund for Drug Abuse Control, to be made up of voluntary contributions and used for the purposes in the above-cited resolutions.

"The discussion which accompanied the adoption of the various resolutions reflected a general consensus that urgent international action was required to deal with problems of drug abuse in order to stem its spread in many parts of the world. I therefore propose to take immediate steps to identify objectives that might be pursued within the level of voluntary contributions expected during the initial years of the Fund and to formulate for consideration and action proposals for a short-term and a long-term policy and programme.

"As called for in the resolutions referred to above, I have established under the existing Financial Regulations the United Nations Fund for Drug Abuse Control to be operated in accordance with trust fund procedures as established by the General Assembly. Governments, non-governmental organizations and private sources are invited to make voluntary contributions for the purpose of combating drug abuse and its disastrous impact on individuals and nations.

"I hope that your Government will respond to the General Assembly's appeal by lending its full support to these efforts aimed at the mobilization of joint international action against drug abuse and will find it possible to contribute generously to the Fund. The attached aide-mémoire provides details on the purposes of the Fund, the initial procedures for utilizing voluntary contributions to the Fund pending the development of a long-term policy and programme of action, the arrangements for making voluntary contributions to the Fund and the initial administrative arrangements for operating the Fund.

"Accept, Sir the assurances of my highest consideration."

U THANT, Secretary-General.

(f) The New Zealand Statement at Fifty-second Session of UNESCO Social Committee Referring to Narcotics Control Board Report for 1971

"We note, however, that to counteract this there has been an equally intense upsurge in international and national activities to control these problems. New Zealand is affected by some of these developments. The abuse of opiates in New Zealand, while still increasing, has not reached a stage where it constitutes a marked social or economic problem. On the other hand, cannabis use is expanding and this is considered to be directly related to the rapidly increasing incidence of hallucinogens on the illicit market. The last year has also seen a considerable increase in drug smuggling. In response to this situation and also as a result of a recommendation passed by the Officials Conference on Drug Trafficking held in Canberra during November 1971 and attended by 13 nations of the South East Asian Region, New Zealand has recently established a National Drug Intelligence Bureau to co-ordinate all facets of information and action regarding illicit drug abuse.

"We would also agree with the broad conclusion that drug abuse trafficking be attacked at all levels, multi-laterally, bilaterally and anti-laterally. Our awareness of the need for total approach involving law enforcement, education, research, aid and rehabilitation activities on all levels is acknowledged in our wholehearted endorsement of the International Narcotics Control Board's views and conclusions. We welcome the fact that the collective wisdom of the Board in these matters is to have greater authority under the terms of the Protocol to amend the Single Convention.

"I wish now to make a few comments on the Secretary-General's report on Use and Dependence Producing Drugs submitted under sub-item E. We commend the sensible tone and attitude adopted in this report and endorse the cautionary note indicating that although there is a large mass of often emotional material on the subject there is a general lack of scientifically collected and evaluted data on the number of young dependent cases and the extent of drug abuse among young people. The report bears out New Zealand's belief that the supply of and demand for illicit drugs must be attacked simultaneously in the fight against drug abuse because one element perpetuates the other. We feel, therefore, that greater effect could be achieved for less outlay by setting up international and national preventive measures against drug traffickers which are the middle link in this chain of supply and demand.

"A concerted plan for action against drug abuse includes development of measures to prevent drug abuse through programmes of education and special campaigns, including the use of mass media. Proposed schedule publications of programmes outlined in paragraph 6 of the Secretary-General's report appear to be a useful start in this area. Enthusiasm should, however, be tempered with caution. Past experience shows that education programmes to date have not been as successful as originally envisaged. We therefore consider it is most important that government involve youth in activities aimed at controlling drug abuse as urged in operative paragraph 1 of the General Assembly resolution 2859 (XXVI).

"Undoubtedly most States agree with the general principles governing this resolution and will agree with the findings of the Secretary-General's

report. Areas of disagreement may centre on the most successful way to achieve the aims embodied in them. For our part we believe that any proposed drug education programmes should be directed towards discouraging the misuse of drugs in general and dependence producing drugs in particular.

"We also consider that undue emphasis on specifically youth-oriented programmes and activities may in fact contribute to the sense of alienation and singularity which seems to be the root cause of many instances of drug abuse. As part of any attempt to realign society's thinking about drugs we believe that there may well be jusification for curbing drug advertising and promotion in all its forms."

APPENDIX IX

NATIONAL DRUG INTELLIGENCE BUREAU, NEW ZEALAND

During recent years Police-Customs co-operation in the area of illicit drug traffic has been the subject of discussion both at national and international level. In particular, recent General Assembly Sessions of the International Criminal Police Organisation (Interpol) have stressed the importance of such co-operation. The South-east Asian Conference on Illicit Drug Trafficking at Canberra in November 1971 also passed a resolution that each country in the region should designate an office where relevant data on illicit drug traffic can be collected and disseminated.

Allied to this are the experiences of other countries who have to contend with a number of agencies, such as federal and state police and Customs without a national bureau.

In March 1972 the Ministers of Health, Police, and Customs jointly approved the establishment of the National Drug Intelligence Bureau in New Zealand. The objective of the bureau is the recording, dissemination, and analysis of all information relating to illicit drug traffic.

Although the primary function relates to enforcement, the Department of Health is also vitally concerned because that department is responsible for the control of the licit drug trade and the "competent authority" for the Single Convention on Narcotic Drugs to which New Zealand is a signatory. They also supply New Zealand representation to the World Health Organisation and report to the United Nations Commission on Narcotic Drugs.

The bureau is under the control of a board, which is responsible for broad policy objectives and general direction. The Commissioner of Police is the chairman, with one other police representative. The Comptroller of Customs and Director, Customs Preventive Service, with a representative from the Department of Health, nominated by the Director-General are board members.

The bureau is at present staffed by two police officers and one Customs officer. The bureau was established on 1 May 1972, and already it has proved valuable in national and international operations.

APPENDIX X

MISUSE OF PRESCRIBED DRUGS

By F. N. Fastier, Professor of Pharmacology, Otago University
(The text of this appendix was broadcast as a radio talk by the NZBC in 1971.)

As you might expect of a pharmacologist, I regard modern drug therapy as one of the supreme achievements of mankind. We can all feel proud that men have landed on the moon, but we have more cause for satisfaction in knowing what can now be achieved through the proper use of drugs. Few people annoy me more than those loud-mouthed cranks who would have you believe that modern drugs are the fruit of a conspiracy to deprive you of both money and health. In some circles the word "drug" has become almost as dirty a word as certain other four-letter words. Had I a time machine, I should love to consign these professed haters of technology to an era when there was no insulin or penicillin, in which pernicious anemia was truly pernicious and consumption could indeed gallop, and in which dental extractions had to be performed without a local anaesthetic and major surgical operations without a general anaesthetic.

Unfortunately, few great discoveries have been unmixed blessings. Who on occasion has not cursed a blaring radio or speeding motor car! The misuse of drugs has become a major problem the world over.

It's a big subject, ranging as it does from lapses of doctor or patient to frank drug abuse, by which I mean the misuse of drugs without medical advice and for reasons other than the sake of one's health. Although I shall say little about drug abuse, I would stress that it cannot be profitably discussed without taking account of popular views on alcohol, tobacco, and such mood-altering drugs as can be obtained only when prescribed by a medical practitioner.

Critics of existing legislation to curb drug abuse have found plenty of ammunition provided by the inconsistent views on drugs held by many older members of the community. The very word "drug" means different things to different people. Whereas some regard any medicine as a drug, others have a much narrower concept of the term, restricting its use to agents which act on the brain. I mention this confusion in terminology because it often leads to blinkered attitudes. Thus a heavy smoker may fail to see himself as a drug-dependent person comparable to, say, an alcoholic or the hypochondriac who is never happy without a bottle of medicine. Pharmacologists, therefore, use the term "drug" in a very broad sense. From a scientific as distinct from a legal viewpoint, it matters little whether a substance capable of affecting any body function happens to be used as a medicine. Pharmacologists regard all such substances as drugs.

It's often claimed that we are a nation of drug takers. The annual cost of the pharmaceutical benefits scheme now exceeds $20 million and the public spends at least another $6 million on self-prescribed medicines.

However, it's important to get present expenditure in perspective. *Per capita* the annual consumption is less than $10. New Zealanders as a whole spend about as much on footwear as on medicines. They

spend much more on alcohol and tobacco. The annual consumption of beer amounts to approximately 23 gallons per head of population and of tobacco, to about 5 lb. Contrary to a widely held opinion, not much of the social security tax is needed to pay for pharmaceutical benefits, only about 3 percent in fact. That is not to say that expenditure on drugs should not get the closest scrutiny. However, it has been unduly criticised.

Most of the money spent on drugs is money well spent. If drugs were eliminated the total health bill would be much greater.

For example, some of you may remember what is was like being treated for an infectious disease like pneumonia or tuberculosis before satisfactory drugs became available. Thanks to such drugs as the antibiotics, there is now less need for hospital care. National statistics bear this out. During the period 1944–45 the number of patients in public hospitals was equivalent to nearly 7 per 1,000 population. In 1954–55 the corresponding figure was 5.5, and in 1964–65 it was 4.5. These figures are the more significant when you remember that in recent years there has been a sharp increase in accident cases and a steadily increasing demand for geriatric treatment. Sanitoria have been made obsolete. A similar improvement can be demonstrated in the field of mental illness. Need I add that illness means more than an item of national expenditure. The benefits of modern drug-therapy are not merely financial.

When you consider what most of us have gained from the proper use of drugs, occasional lapses do not seem an unreasonable price. Some members of a community are bound to be unduly stupid, careless, or unreasonable. The reckless and the feckless are always with us! The important thing is to minimise the trouble they create by discovering where it is likely to occur. And that gets me to a basic question: what benefits do various patients expect to get from drug therapy?

Many of the patients who come to doctors have forms of illness which can be not only readily diagnosed but also treated appropriately mainly by drug therapy. For example, it's rational in the management of an infectious disease to prescribe a drug which is known to kill the microbes responsible for that type of disease. Similarly, it is rational to prescribe such a drug as insulin, vitamin B12, or an iron salt when a patient is suffering from a deficiency disease. In many circumstances benefit from drug therapy can be expected for reasons which have become clear through advances in medical science. There are other circumstances, however, in which prescribing a medicine is thoroughly justifiable.

Even today we cannot explain why certain drugs have been found valuable for treating particular conditions. This so-called "empirical" use of a drug is not to be condemned provided that there's good evidence that the drug works. Not so long ago we could not have explained why colchicine relieves an acute attack of gout or why cinchona bark is useful for treating malaria. We have yet to discover why aspirin can relieve a headache or why morphine can make one feel much less concerned about a severe pain.

The use of a "placebo" is more open to question. This term means in Latin "I shall please". A placebo is a dummy medicine given to please the patient. The effects cannot be explained in terms of the dosage or pharmacological properties of the constituents. Yet in some

patients a placebo may have a dramatic effect. It's remarkable what can be done by the power of suggestion when confidence in the doctor is accompanied by a belief in magic out of a bottle. The fact that the placebo may contain no drug which would conceivably exert a direct useful action on any organ of the body is immaterial so long as the physician who prescribes a placebo frankly recognises that he is giving a psychotherapeutic as distinct from a pharmacological agent.

Unfortunately, from the physician's standpoint, it often happens that a patient's illness cannot be explained at least in large measure by some physical derangement. The symptoms may be those of an underlying neurosis. Body and mind are so intimately bound up that ill-health is seldom confined to the one. A patient may have some insight into his condition. Thus, he may realise that his indigestion is a symptom of a disorder originating in some unsatisfactory personal relationship. More often he requests therapy which is palliative at best.

Granted that most general practitioners in New Zealand are overworked, what can they reasonably be expected to do in the management of so-called psychosomatic disorders? Our world's got into a sorry state when we find it's the physician rather than the priest who's called on to teach persons how to face up to emotional problems. It's important in this connection to distinguish between providing psychotherapy, which is very much the business of the physician, and providing a basic satisfying philosophy of life. Without this philosophy persons can be expected to go under when they run into trouble.

Which gets me back to drug therapy. I began by pointing out how some persons grossly under-rate its importance. Many others make the opposite mistake. As you may wonder how they've come to expect too much of drugs, let me point out some complicating factors. I've already referred to "the power of the placebo". The assessment of remedies is difficult for yet other reasons. For instance, a drug may be given credit for what was really the wonderful recuperative power of the body. It's not widely appreciated that of all those who fall sick, the great majority would recover even if they were to receive no treatment. Ignorance of this fact has been partly responsible for a vast mythology in which drugs may acquire a semi-magical aura. So long as many patients have unwarranted expectations of drug therapy, they can be expected to create medical problems, at least until the medical profession takes concerted action to lessen the misuse of such drugs as hypnotics, tranquillisers, "pep pills", analgesics, digestants, and vitamins. All of these drugs have valid uses. What concerns me is their use in circumstances where better therapy is indicated.

Two good examples of conditions which have often given rise to the misuse of drugs are insomnia and constipation. These could be called "pseudo-diseases", since they are seldom harmful though laymen are apt to regard them as diseases in their own right. Not so long ago most people were so concerned about their bowel movements that any deviation from a supposed normality was treated by taking drugs, a practice which in the long run is far more likely to do harm than good. Eventually doctors got round to believing that the defence of the general public against the misuse of purgatives was an important task of preventive medicine. I wish that a similar improvement could

be induced in lay attitudes towards insomnia. The present situation is disquieting. Various statistics indicate that a substantial proportion of New Zealanders must be taking hypnotics habitually. One consequence of the prescribing of large amounts of barbiturate hypnotics is that these drugs have become favourites for suicide attempts.

Tranquillisers and other mood-altering drugs are also being prescribed on a very large scale. Can this be justified? You don't have to be a perfectionist to feel that more than palliative therapy is needed for such patients as those middle-aged women whose basic trouble is that they no longer have enough worthwhile things to do. Yet a realist might claim that this is all the treatment that an overworked G.P. is in a position to provide.

Pharmacologists try to stick to a simple criterion: the benefit likely to accrue from the use of a drug should clearly outweigh the possible harm. Like surgery, drug therapy is seldom devoid of risk. Unwanted effects usually show up fairly quickly, but some can be quite insidious. The harm may be physical, as when a patient becomes hypersensitive to a drug possibly long after first exposure to it. The harm may be mental in that the patient becomes so habituated to a form of therapy that he wants it continued long after the need for it has disappeared. For instance, there is a widespread impression—which ought to be checked—that many patients have become habituated to taking hypnotic drugs as the result of a spell in hospital.

Now I don't have to be told that there are circumstances in which the needs of an individual should be subservient to those of a group. Thus, when the critical shortage of nurses is taken into consideration, it may be in the interests of a ward that a noisy patient be tranquillised. The patient himself may ask for a hypnotic each night. The immediate benefit must be balanced against the possibility of long-term undesirable effects.

There are various other situations in which a physician accused of overprescribing can plead mitigating circumstances. However, inexcusable overprescribing occurs sufficiently often to call for more than mild remonstrance. Some shocking examples of it have been brought to my attention. Granted—there are a few patients who could "con" almost any doctor but there are numerous others who do not provide undue "patient pressure". They deserve better than the mere renewal of useless prescriptions or, worse, the modern equivalent of blunderbuss therapy.

Any large professional group is bound to contain some persons whose standards cause concern to their fellows. Though I speak as an outsider, I nevertheless believe that the medical profession deals firmly with its black sheep. However, I also believe that it is liable to pussyfoot when dealing with incompetence or carelessness as distinct from roguery. Naturally doctors called upon to judge a fellow are likely to think "there but for the grace of God go I", and act accordingly. While I sympathise with this viewpoint, I believe that if it is given too much weight patients will be the more inclined to seek redress in ordinary courts. And when malpractice suits become common, as in parts of the United States, neither the medical profession nor the public benefits. . . . It's much better for the medical profession to keep its own house in order.

APPENDIX XI

SOME SIGNIFICANT DEATHS ARISING FROM DRUG OVERDOSAGE

Appendix IX of the first report gave short reports on five significant deaths arising from drug overdosage.

It is with regret that notes are given in this appendix of a substantially greater number of deaths than were recorded in the first report. The majority of these deaths have occurred in relation to the use of methadone in situations where misuse or abuse of prescribed supplies was a predictable outcome.

Drug Deaths: May 1972 – May 1973

Date of Death	Place	Age	Sex	Drug Involved	Cause of Death
18/5/72	Christchurch	29	Male	Opiates	Subject was an addict. Pulmonary congestion and granulomatous disease of lungs consistant with intravenous injection of opiate drugs.
8/6/72	Christchurch	18	Male	Opiates	"
29/7/72	Christchurch	23	Male	Opiates	"
28/6/72	Hamilton	47	Female	Paracetamol, quinalbarbitone, diazepam	Subject was a chronic hypochondriac and an alcoholic. Drowned in bath while under influence of drugs.
15/7/72	Auckland	25	Male	Dextromoramide (Palfium)	Overdose.
28/8/72	Auckland	21	Male	Methadone	Methadone and barbiturate poisoning.
1/9/72	Auckland	17	Male	Methadone	Methadone poisoning.
3/9/72	Auckland	20	Male	Methadone	Methadone poisoning.
10/9/72	Auckland	20	Male	Methadone and Palfium	Methadone poisoning.
4/10/72	Auckland	26	Male	Methadone	Inhalation of vomit whilst under influence of methadone.
18/10/72	Auckland	26	Male	Methadone and Mandrax	Overdose of Mandrax.
26/12/72	Auckland	20	Male	Methadone	Methadone poisoning.
10/9/72	New Plymouth	21	Male	Methadone	Overdose.
1/12/72	Wanganui	21	Female	Valium, Tuinal, Hygroton	Respiratory depression through overdose.
2/3/73	Auckland	22	Male	Methadone	Inhalation of vomit whilst under influence of methadone. Also suffering from peritonitis.
3/3/72	Auckland	22	Male	Methadone	Overdose.
14/3/73	Auckland	30	Male	Methadone	Car accident—under influence of methadone.
6/5/73	Wellington	27	Male	Methadone	Suspected overdose—coroner's hearing pending.
12/5/73	Wanganui	22	Male	Cannabis and alcohol	Car accident.

APPENDIX XII

THE PRESCRIBING OF HYPNOTICS, TRANQUILLISERS, AND STIMULANT DRUGS IN NEW ZEALAND

A STUDY OF TRENDS OVER A THIRTEEN YEAR PERIOD

by

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(Received July 1972)

SUMMARY

The prescribing of hypnotics in July 1958 was compared with the use of hypnotics and tranquillisers (and stimulant drugs) in July 1971—13 years later.

In 1958, on any particular night 1.1 percent of the population (about 25,000 people) and 2.5 percent of married women (or widowed, separated, or divorced*) took a hypnotic ordered by a doctor at the cost of public funds.

By 1971, despite the widespread use of the minor tranquillisers which had been introduced in the interim, 1.96 percent of the population (about 56,000 people) and 4.9 percent of married women were taking hypnotics on an average night. The figures for unmarried women, and men, had increased only from 1.2 percent and 1 percent respectively, to 1.6 percent for each group. Of married women, about one-third of those taking hypnotics (1.7 percent) were taking them regularly and for long periods of time.

On an average day in 1971, 3.7 percent of the population took a tranquilliser; while 5 percent took a hypnotic, a tranquilliser, or both. The corresponding figures for married women were 8.3 percent and 11.6 percent.

Married women in rural areas receive a significantly smaller proportion of hypnotics and tranquillisers amongst the drugs prescribed for them by doctors, than those living in towns or cities. The size of the place in which the *urban* married woman lived appeared, however, to have little or no influence on her liability to receive these drugs. With adult males, and unmarried adult females, proportionately more of these drugs were issued in towns than in rural areas, and in cities than in towns.

Mogadon, a very safe non-barbiturate hypnotic, is the most widely prescribed hypnotic (33.4 percent of total hypnotic use, and 44.3 percent of the cost to the taxpayer). Two related products, Valium and Librium, between them account for 63.3 percent of tranquilliser use, and 74.5 percent of the cost to public funds.

On the other hand, the third most-popular hypnotic is a drug which was the subject of a strongly worded warning issued to doctors in June 1970. A year later, 39 percent of doctors were still ordering it.

*This qualification is to be understood wherever "married women" are referred to in this paper.

On the whole, doctors who ordered fewer hypnotics also tended to use fewer tranquillisers. This was true of both rural and urban doctors. Tranquillisers, as employed at present by most doctors, do not reduce the use of hypnotics.

Some 3.8 percent of established general practitioners prescribe hypnotics very sparingly, if at all. Apart from these very restricted prescribers, if all doctors prescribed in the same way as the next most conservative 26.5 percent, the percentage of the population taking hypnotics, tranquillisers, or both on an average day would fall from 5 percent to 3.2 percent, with a saving to public funds of at least $870,000 per annum, and, it is suggested, considerable benefit to health and wellbeing.

In brief, hypnotics are now being used at double the level of 13 years ago, while tranquillisers (a new factor in the situation) are costing the taxpayer not less than $2.4 million a year. Hypnotics plus tranquillisers are costing $1.11 a head of population per annum, as compared with 9.6c a head for hypnotics in 1958.

One factor in this disturbing situation is believed to be shortage of doctors, and inadequate time to deal with patients, particularly those with psychological problems.

The four stimulant drugs in the Drug Tariff were very modestly prescribed at the cost of public funds, but this in no way reflects the position as a whole in New Zealand.

I. INTRODUCTION

The investigation described in this paper falls into two parts.

The first is a study of the prescribing of hypnotics in New Zealand in July 1958. The second deals with the prescribing of hypnotics, tranquillisers, and stimulant drugs 13 years later, in July 1971. Each was based on random samples of prescriptions issued by doctors in active private practice. (See note 1.)

The results of the first investigation were presented at a conference of the British Medical Association in 1959, but have not previously been published.

By a fortunate accident, this 1958 enquiry was carried out at the very climax of the consumption of barbiturates in this and other countries. From 1960 onwards, the introduction of the minor tranquillisers rapidly brought about a radical change in the prescribing situation, as they elbowed out the barbiturates as daytime sedatives. Little affected by their non-barbiturate hypnotic rivals until 1965, from then onwards two remarkably popular drugs, Mogadon and Mandrax*, made substantial and fast-growing gains at the expense of the barbiturates. At the same time, although phenobarbitone is still used today in the treatment of epilepsy, its place was being taken to an increasing extent, year by year, by other anticonvulsants.

*In this paper, brand names are used whenever the official name is cumbersome and unlikely to be familiar to the average reader.

Previous Studies

In 1958 it was common knowledge that about 10 percent of the world's prescriptions were for barbiturates. This figure was established in surveys [1,2] of English and Scottish prescribing in 1952 and 1953, and similar results were obtained in studies of all countries in the Western European Union, in the United States, and in this country. [4,5] (For particulars of previous New Zealand Studies, see note 2.)

At that time, however, as mentioned above, barbiturates were frequently used for daytime sedation and in epilepsy. When preparing the first (1958) paper, the present writer was unable to trace any studies of the proportion of prescriptions actually intended to induce sleep. This 1958 study was not confined to the barbiturates, but dealt with the prescribing of hypnotics of all types.

A weakness of most studies of this kind is that they measure drug use in terms of "prescriptions". In the present survey the period of supply of prescriptions for the same drug ranged from 2 days to 120 days—despite the fact that in the New Zealand social security scheme the maximum quantity permitted is sufficient for 3 months*. Prescribing habits vary from doctor to doctor, from place to place, and from time to time. A prescription count is, therefore, a crude and unreliable method of assessing drug usage.

Units of Measurement Employed in this Survey

The last-mentioned difficulty was overcome by measuring hypnotics in terms of "sleeps", and tranquillisers and stimulants in terms of so many days' supply.

Using this method, a "sleep" depends on the quantity of hypnotic ordered to be taken at night. This varies considerably. One prescription for 30 capsules may represent 30, 20, or 15 "sleeps", depending on whether the instructions read "One at night", "1 or 2 at night", or "Two at night".

Prescriptions for tranquillisers and stimulants were treated similarly, each being evaluated in terms of so many "days".

A therapeutic assessment was made of every prescription. No prescription was accepted as a "sleep script" unless it specified a hypnotic dose to be taken at bedtime. Not infrequently a tranquilliser (usually Valium) was ordered to be taken only at bedtime; even so, this was classified as a prescription for a tranquilliser and assessed in "days". All 90-day prescriptions for phenobarbitone were excluded (because some of these patients might be epileptics), as was any other prescription form which included an anticonvulsant drug.

The survey was confined to drugs included in the New Zealand Drug Tariff, and to prescriptions dispensed by retail pharmacists. (See note 3.)

For these and other reasons†, all estimates of drug usage in this paper must err on the conservative side. Reasons are given in note 2 for believing that they understate the actual situation by at least 15 percent.

*Some doctors ordered 180 capsules, "Sig: 1 or 2 at night". On the average this amounts to a 120-day supply.

†For example, in order to get round the New Zealand quantity restrictions, some doctors order, say, two capsules to be taken at a dose, but tell the patient that one should be sufficient. So a supply reckoned here as 30 "sleeps" may actually be sufficient for 60.

"Cost" in this survey means the cost to public funds under current conditions of practice and rules for payment. It is affected by the number of doses ordered per prescription, the number of dispensing fees involved, and sometimes by the method of presentation. (For example, extemporaneously compounded capsules, not infrequently ordered in 1958, are relatively expensive.)

To avoid confusion, some other terms used in this paper must be clarified.

When a doctor writes a prescription, he does so on a sheet of paper, which is herein referred to as a "form". On this form he may order one item (say 20 capsules of a named drug), or he may order several different items, each to be issued in a separate container. In this paper these items are called "prescriptions", and this is the usually accepted international meaning of that word. (Occasionally the contraction "script" is used instead.)

In this country, however, the customary official method of counting "prescriptions" is different. If an item ordered by the doctor is dispensed in, say, monthly lots, or if repeats are ordered, each dispensing is counted as one "prescription", because each is subject to a separate claim for payment. The result is that by international standards the official figures for "prescriptions" issued in New Zealand overstate the position by about 25 percent. For international comparisons they should be reduced by one-fifth.

So in this paper the terms employed are:

"Forms"—the pieces of paper upon which prescriptions are written.

"Prescriptions"—the separate items ordered on these forms.

"Claims"—the number of separate dispensings claimed for by the pharmacist.

Forms are important units of measurement, because the vast majority represent all the medication ordered at one interview between doctor and patient. At present, the average form issued in New Zealand contains 1.84 prescriptions (in the sense in which the word is used in this paper) and is the subject of 2.31 claims by the pharmacist.

II DESIGN

Objects

Answers were sought to the following questions:

(a) What percentage of prescriptions are intended to induce sleep? Or to "tranquillise"?

(b) On any particular night, how many New Zealanders take a sleeping drug prescribed by a doctor?

(c) In any period of 24 hours, how many take a tranquilliser or a stimulant drug?

(d) Which are the most popular drugs in these classes, and how do they compare in cost?

(e) What is the cost to public funds?

(f) What type of patient takes most of these drugs?

(g) How do town dwellers compare with country people?

(h) Is there any discernible relationship between seniority in the prescriber and proneness to order these drugs?

(i) How many people are taking hypnotics regularly and for long periods of time?

(j) How many repeats or extended supplies for hypnotics and tranquillisers are not collected by patients?

(k) In 13 years, what effect (if any) has the use of tranquillisers had on the prescribing of hypnotics?

Method

In the 1958 survey, mixed batches of prescriptions totalling 24,000 were examined. They were mainly written in July 1958. The sample amounted to 2.5 percent of all prescriptions written in that month, and included prescriptions from a random sample (limited to those receiving at least £2,000 per annum for general medical services) of 168 doctors, or about 10 percent of all doctors claiming for general medical services benefits.

Lessons learned in the previous survey were applied in the 1971 study.

On this occasion the sample of doctors was confined to general practitioners without any known specialist interest. Only those receiving not less than $4,000 for general medical services in 1970–71 were included. The sample of 185 doctors was equivalent to 15 percent of the total number of general practitioners in active practice in each of the 15 health districts which handle general medical services claims. A hundred forms issued by each doctor in or about July 1971 were examined, totalling 34,006 prescriptions (or 42,753 claims). These represented 2.4 percent of prescriptions issued in that month.

In each survey, prescriptions issued in the four pricing office areas into which New Zealand was divided in 1958*—Auckland, Wellington, Christchurch, and Dunedin—were analysed separately, in an attempt to bring out any regional differences.

III. FINDINGS

(a) What Percentage of Prescriptions are for Hypnotics or Tranquillisers?

In 1958, about 4 percent of all prescriptions were for hypnotics. In 1971 the figure was 3.2 percent, but about 10 percent of all prescriptions in that year were for hypnotics or tranquillisers, or both.

*Later reduced to three.

The figures by pricing office areas were:

Table I—Percentage of Prescriptions which were for Hypnotics or Tranquillisers

	Percentage for Hypnotics		Percentage for Hypnotics and/or Tranquillisers
	1958	1971	1971
	Percent	Percent	Percent
Auckland ..	4.1	2.9	9.7
Wellington ..	4.0	3.4	10.6
Christchurch ..	4.3	3.3	11.6
Dunedin ..	3.3	3.6	10.6
Dominion (percentage)	4.04	3.17	10.32

Figures such as these must be interpreted with caution. Apart from the shortcomings mentioned above, of reckoning by "prescriptions", differences between districts in age* and sex distribution, and the ratios of rural to urban dwellers, as well as changes in volume of prescribing and population size must be taken into account. In 13 years, hypnotic prescriptions per 1,000 population remained unchanged (at about 180 per annum) but the consumption of hypnotic drugs increased by 78 percent. (See below.)

(b) **On any Particular Night, How Many New Zealanders Take a Hypnotic Prescribed by a Doctor?**

In 1958 the answer was 1.1 percent of total population—about 25,000 people. In 1971 it had risen to 1.96 percent, or about 56,000 people. This staggering increase has taken place despite the fact that we in this country are probably amongst the world's leading consumers of tranquillisers.

By pricing office areas the figures were:

Table II—Hypnotic "Sleeps" per 1,000 Population Nightly

Pricing Office Area	"Sleeps" per 1,000 Population	
	1958	1971
Auckland	12.6	19.9
Wellington	9.5	19.9
Christchurch	10.8	16.9
Dunedin	8.8	22.0
Dominion (percentage)	1.1	2.0

Some of the reservations mentioned above in relation to table I apply here also; but the extent of the increase in the Dunedin figures in particular should be noted.

*It is known that elderly people use more hypnotics than persons in younger age groups, but this factor could not, unfortunately, be evaluated in the present survey.

(c) On Any Particular Day, How Many People Take a Tranquilliser or a Stimulant Drug?

In 1958 the minor tranquillisers had not been introduced, and figures for stimulant drugs in that year are no longer available.

In 1971 the figure for tranquillisers was 3.68 percent (about 105,000 persons). For stimulant drugs (amphetamines and Ritalin) the figure was only 0.17 percent (about 4,800 persons). These comprise, however, only persons taking a stimulant drug included in the Drug Tariff (see page 180) and ordered by a doctor at the cost of public funds.

Amphetamines are not expensive. It is not known what quantities were purchased by patients on non-social security prescriptions issued by doctors, or were obtained from irregular sources.

(d) Which are the Most Popular Drugs, and How Do They Compare in Cost?

(i) *Hypnotics*—In 1958 the two least expensive hypnotics, phenobarbitone and butobarbitone (Soneryl) were also the most popular.

By 1971 butobarbitone had moved from first to second place, being replaced by Mogadon, a relatively expensive but very safe non-barbiturate hypnotic. In third place we find Mandrax, a non-barbiturate which not only "shares most of the disadvantages of the barbiturate hypnotics (hangover, potentiation of the actions of alcohol, risk of dependence) but also possesses additional hazards such as very rapid onset of action in some patients, abuse by teenagers, and coma from overdose (which) may be complicated by convulsions".[6] In this country, in June 1970, the National Poisons Information Centre mailed to all doctors a strongly worded warning, printed in red, about Mandrax poisoning, pointing out that the use of Mogadon, Adumbran, or Serepax exclusively as hypnotics in outpatients "might abolish most of the serious problems associated with overdosage of hypnotics". Twelve months later, 39 percent of the doctors included in this survey were still prescribing Mandrax.

The following tables show the position in detail:

Table III—1958 Popularity and Cost of Hypnotics

Drug	Percentage of Total Use*	Cost per "Sleep"	Share of Hypnotic Cost to Taxpayer
	Percent	cents	Percent
1. Butobarbitone (Soneryl)	32.0	1.6	21.1
2. Phenobarbitone ..	20.0	0.8	6.6
3. Amylobarbitone ..	18.0	4.1	30.3
4. Nembutal	12.0	3.1	15.3
5. Seconal	6.0	4.2	10.4
6. Chloral and Bromide ..	4.3	2.5	4.4
7. Barbiturate combinations	2.4	5.7	5.6
8. Chloral (plain or with opium)	1.7	2.3	1.6
9. Barbitone	1.7	2.3	1.6
10. Cyclobarbitone ..	1.3	3.7	2.0
11. Hexobarbitone ..	0.6	4.3	1.1

Average cost: 2.5c per "sleep".

*In terms of prescriptions.

Table IV—1971 Popularity and Cost of Hypnotics

Drug	Percentage of Total Use*	Cost per "Sleep"	Share of Hypnotic Cost to Taxpayer
	Percent	cents	Percent
1. Mogadon	33.5	4.3	44.3
2. Butobarbitone ..	17.0	1.5	8.2
3. Mandrax	14.7	3.1	14.0
4. Tuinal	9.8	3.1	9.3
5. Amylobarbitone ..	9.5	2.6	7.7
6. Doriden	4.9	3.4	5.2
7. Seconal	3.2	2.5	2.5
8. Nembutal	2.9	3.1	2.8
9. Chloral (various forms)	1.4	5.4	2.4
10. Phenobarbitone ..	1.1	1.7	0.6
11. Melsedin	0.8	3.8	0.9
12. Noludar	0.5	5.6	0.8
13. Censedal	0.5	7.5	1.1
14. Cyclobarbitone ..	0.2	2.5	0.2

Average cost: 3.2c per "sleep".

*In terms of "sleeps" ordered.

(ii) *Tranquillisers*

Table V—1971 Popularity and Cost of Tranquillisers

Drug	Percentage of Total Use†	Cost Per Diem	Share of Tranquilliser Cost to Taxpayer
	Percent	cents	Percent
1. Valium	42.5	7.3	52.5
2. Librium	20.8	6.3	22.0
3. Amylobarbitone ..	8.9	1.9	2.9
4. Phenobarbitone ..	7.1	1.4	1.7
5. Largactil	4.0	4.4	2.9
6. Melleril	3.2	5.4	2.9
7. Vallergan	2.8	5.0	2.3
8. Anatensol	2.7	7.9	3.6
9. Serepax	2.5	6.9	2.9
10. Adumbran	2.1	7.3	2.6
11. Meprobromate (Equanil, Meprospan)	1.9	5.5	1.7
12. Trilafon	0.9	6.5	1.0
13. Censedal (as a tranquilliser)	0.2	7.4	0.2
14. Neulactil	0.2	15.0	0.4
15. Sevinol	0.1	17.1	0.3
16. Sparine	0.1	6.4	0.1

Average cost: 6c per diem.

†In terms of treatment days.

It is noteworthy that two closely related drugs, Valium and Librium, accounted between them for 63.3 percent of tranquilliser use, and 74.5 percent of the total cost of tranquillisers to public funds.

(iii) *Stimulant Drugs*—There were only four drugs in this class in the Drug Tariff in 1971—three amphetamines, and Ritalin (methylphenidate hydrochloride), which is not a member of the amphetamine group.

No figures are available for 1958.

Table VI—1971 Popularity and Cost of Stimulant Drugs

Drug	Percentage of Total Use	Cost per Diem	Share of Stimulant Cost to Taxpayer
	Percent	cents	Percent
1. Dexamphetamine ..	43.6	1.6	27.5
2. Ritalin	37.7	4.0	59.5
3. Methylamphetamine ..	16.3	1.8	11.7
4. Amphetamine ..	2.4	1.4	1.3

Average cost: 2.6c per diem.

(e) **What is the Cost to Public Funds?**

(i) *Hypnotics*—

Table VII—Changes in Hypnotic Costs Between 1958 and 1971

	1958	1971
Average cost per "sleep"	2.5c	3.2c
Cost per prescription	44c	$1.27
Average cost, all prescriptions ..	80c	$1.68
Cost of hypnotics per head per annum (total population)	9.6c	28.3c
Total cost of hypnotics to taxpayer ..	$221,500	$811,500
Percentage of total cost of pharmaceutical benefits	2.2%	2.4%

In the same period, the total cost of pharmaceutical benefits more than trebled—from $10.2 million to $33.2 million. This explains why the hypnotic share of this expenditure showed only a very minor increase (2.2 to 2.4 percent) despite the fact that the *per capita* consumption of hypnotics had almost doubled (see page 177) and the cost per "sleep" had also increased.

(ii) *Tranquillisers*—Although in 1958 some of the barbiturates were used to a modest extent for daytime sedation, and Largactil was prescribed by some general practitioners, the cult of the "minor tranquillisers" was yet to come. No figures are available for 1958, but there can be little doubt that the total cost of drugs used in this manner at that time was small.

The position in 1971 was very different:

Table VIII—1971 Cost of Tranquillisers to Public Funds

	1971
Tranquillisers: average cost per diem	6.0c
Cost per prescription	$1.31
Average cost, all prescriptions	$1.68
Cost of tranquillisers per head per annum (total population)	82.2c
Total cost of tranquillisers to taxpayer	$2,356,000
Percentage of total cost of pharmaceutical benefits ..	7.1%

Between them, at a conservative estimate (see note 2), in 1971–72 hypnotics and tranquillisers cost the New Zealand taxpayer about $3,167,500. This amounted to $1.11 per head of total population, or 9.5 percent of the total cost of pharmaceutical benefits. These figures may be compared with the cost per head of hypnotics in 1958—9.6c.

(iii) *Stimulant Drugs—*

Table IX—1971 Cost of Stimulant Drugs to Public Funds

	1971
Stimulants: average cost per diem	2.6c
Cost per prescription	94c
Average cost, all prescriptions	$1.68
Cost of stimulant drugs per head per annum (total population)	1.6c
Total cost of stimulant drugs to taxpayer	$46,600
Percentage of total cost of pharmaceutical benefits ..	0.14%

These modest figures do not, of course, reflect the true position in regard to the use of stimulant drugs in New Zealand, since the inquiry was confined to drugs prescribed by doctors at the cost of public funds.

(f) **What Type of Patient Takes Most of These Drugs?**

(i) *Hypnotics*—The significance of this question was not fully appreciated when the 1958 survey was planned. Prescriptions were split up by designation ("Mrs", "Mr", "Miss", initial only) and those which were obviously for children, but no attempt was made to check the accuracy of this classification with the doctors involved.

The following results were obtained:

Table X—1958 Distribution of Hypnotic Prescriptions

Designation	Percent
"Mrs"	59.4
"Mr"	27.8
"Miss"	7.5
Initial only	1.9
Obviously a child	3.5

On the assumptions that "Miss" meant an unmarried adult female, and initials only an adult male (both of which are obviously subject to exceptions), the following emerged:

Table XI—1958 Percentage of Group Taking a Hypnotic on any Particular Night

	Percent
Married women (or widowed, separated or divorced)	2.50
Women, never married	1.20
Adult males	1.00
Children	0.08
Whole population ..	1.1

It appeared, therefore, that married women (or widowed, separated, or divorced) received about three-fifths of all hypnotic prescriptions, and considerably more than twice as much hypnotic medication as their husbands. They also received twice as many hypnotics as their unmarried adult sisters.

A rough check appeared to show, however, "that the share of hypnotics consumed by married women, although relatively high, was in proportion to their usage of medication as a whole".

This observation was examined in detail in the 1971 survey, and was found to be faulty.

Hypnotic Situation in 1971—In the 1971 survey every prescription for a hypnotic or a tranquilliser where the classification of the patient was in doubt, was referred back to the prescriber for his guidance. Two of the 108 doctors concerned had unfortunately died in the interval. Of the remainder, only three failed to reply promptly. Their prescriptions were verified by other means.

Table XII—1971 Percentage of Group Taking a Hypnotic on a Particular Night

(1958 figures in brackets, for comparison)

	Percent	Increase Percent
Married women (or widowed, separated, or divorced)	4.90 (2.50)	96
Females over 16, never married	1.60 (1.20)	33
Males over 16 years	1.60 (1.00)	60
Children (i.e., under 16, both sexes) ..	0.08 (0.08)	Nil
Whole population	1.96 (1.10)	78

The most noteworthy feature is that the proportion of married women taking hypnotics almost doubled in 13 years, and the contrast between them and their unmarried sisters is greater than ever: three times as many of them are now taking hypnotics, instead of twice as many, as in 1958.

(ii) *Tranquillisers*—

Table XIII—1971 Percentage of Group Taking a Tranquilliser on an Average Day

(Figures for 1958 not available)

	Percent
Married women (or widowed, etc.) ..	8.30
Females over 16, never married ..	3.50
Males over 16 years	3.30
Children	0.54
Whole population:	3.68

(iii) *Hypnotics, Tranquillisers, or Both—*

Table XIV—1971 Percentage of Group Taking a Hypnotic, Tranquilliser, or Both

(Allowing for overlap)

	Percent
Married women (or widowed, etc.) ..	11.6
Females over 16, never married ..	4.5
Males over 16 years	4.4
Children	0.6
Whole population	5.0

(iv) *Share of Prescribing Taken by Married (etc.) Women*—By relating population distribution in three main groups (married (etc.) women, adult males, and others) to the share of prescriptions issued to each group, we find that while married (etc.) women, as compared with the other two groups, receive about double their share of prescriptions of all kinds, they take an even larger share when it comes to hypnotics and/or tranquillisers.

In the following table, if prescription issues to any group were in proportion to their share of the population, the figure would be unity (1.00):

Table XV—1971 Share of Annual Prescriptions Issued, Divided by Share of Population

Group	Prescriptions	
	All Types	Hypnotics and/or Tranquillisers
"Mrs"	1.64	2.31
"Mr"	0.87	0.90
Others	0.71	0.31
Whole population ..	1.00	1.00

(v) *Stimulant Drugs—*

Table XVI—Percentage of Group Taking Stimulant Drugs on Average Day

Group	Amphetamines Percent	Ritalin Percent	Total Percent
"Mrs"	0.28	0.17	0.45
"Mr"	0.04	0.05	0.09
Adult female	0.18	0.04	0.22
Children	0.02	0.01	0.03
Total ..	0.09	0.06	0.15

(g) How do Town Dwellers Compare with Country People?

This question was considered briefly in the 1958 survey, but the results were equivocal and inconclusive. The probable reason was that allowance was not made for the differences in hypnotic consumption between married women and other people.

In the 1971 survey, doctors were classified by the populations of the localities in which they practised as designated rural, town doctors (population 5,000–20,000), and city doctors (over 20,000 population). This gave 35 rural doctors, 35 town doctors, and 115 city doctors. Forms issued to married (etc.) women ("Mrs"), adult males, and unmarried adult females, were studied separately.

Table XVII "Sleeps" and Tranquilliser "Days" per 100 Prescription Forms

(a)—1971: Married Women by Type of Practice

Classification of Practice	Number of Doctors	Number per 100 "Mrs" Prescription Forms		
		"Sleeps"	Tranq. "Days"	"Sleeps" plus "Days"
Rural	35	246	619	865
Towns	35	379	798	1,177
Cities	115	404	762	1,164
Rural figures as percentage of towns and cities ..	..	61.7	80.6	74.1

Married women in designated rural areas received a significantly smaller proportion of hypnotics and tranquillisers amongst the drugs prescribed for them by doctors, than those living in towns or cities. The size of the place in which the urban married woman lived appeared, however, to have little or no influence on her liability to receive these drugs.

(b)—1971: Adult Males by Type of Practice

Classification of Practice	Number of Doctors	Number per 100 "Mr" Prescription Forms		
		"Sleeps"	Tranq. "Days"	"Sleeps" plus "Days"
Rural	35	157	349	506
Towns	35	204	484	691
Cities	115	286	649	935
Rural figures as percentage of town figures ..	..	77.0	72.1	73.2
Town figures as percentage of city figures ..	..	71.3	74.6	73.9

With adult males, the proportion of hypnotics and tranquillisers issued was higher in town than in rural dwellers, and higher in cities than in towns. The gradient in all cases is remarkably smooth (71.3–77 percent). These differences are statistically significant.

(c)—1971: Unmarried Adult Females by Type of Practice

Classification of Practice	Number of Doctors	Number per 100 "Miss" Prescription Forms		
		"Sleeps"	Tranq. "Days"	"Sleeps" plus "Days"
Rural	35	45	191	235
Towns	35	126	375	501
Cities	115	213	462	675
Rural figures as percentage of town figures ..	..	35.7	50.9	46.9
Town figures as percentage of city figures ..	..	59.2	81.2	74.2

Unmarried adult females, as we have seen, consume much fewer hypnotics or tranquillisers than their married sisters, but they also differ from them in experience as between towns and cities. As with adult males, the town figures are higher than the rural, and cities are higher than towns.

These tables are interesting, but hardly surprising. One would expect rural dwellers of both sexes to be less prone to use hypnotics or tranquillisers than urban dwellers. On the other hand, the situation of the suburban housewife in New Zealand is much the same in Wellington as it is in Levin. With adult males and single women, however, city practices would include a larger proportion of persons holding responsible posts of an executive, administrative, or managerial nature than practices in smaller towns, and one would expect increased tension to be reflected in the doctors' prescribing patterns.

(h) Is there Any Relationship Between Seniority in the Prescriber and Proneness to Order Hypnotics and/or Tranquillisers?

There appeared to be a tendency, in the 1958 survey, for the prescribing of hypnotics to be less lavish amongst recent graduates and in doctors qualified for over 22 years, than in the remainder.

Detailed studies of the 1971 figures failed to show any constant relationship between seniority in the doctor and the proportion of "sleeps" plus "tranquilliser days" per prescription form.

(i) How Many People are Taking Hypnotics Regularly and for Long Periods of Time?

It is reasonable to assume that any patient who receives 90 days' supply (or more) of a hypnotic in one prescription falls into this category.

In the 1971 survey a total of 163 patients received 90-day hypnotic prescriptions. They were distributed as follows:

	Patients
"Mrs"	108
"Mr"	46
Other	9
Total	163

The drug ordered was:

	Number	Percentage
1. Mogadon	47	28.8
2. Soneryl	26	16.0
3. Mandrax	22	13.5
4. Amylobarbitone	21	12.9
5. Tuinal	20	12.3
6. Seven other drugs	27	16.5
	163	100

Assuming that continuous hypnotic consumers receive four 90-day prescriptions per annum, the estimated numbers of continuous takers were:

Table XVIII—1971: New Zealand—Estimated Numbers of Continuous Hypnotic Takers

	"Mrs"	"Mr"	Unmarried Adult Females	Whole Population
Total continuous hypnotic takers in category	12,730	5,422	825	19,213
Percentage of this group	1.7%	0.67%	0.42%	0.67%
Percentage of these who are— ..				
Non-rural	87%	91%	100%	89%
Rural	13%	9%	Nil	11%

About 19 percent of New Zealand's population is served by doctors in designated rural practices. The disproportion between non-rural and rural in this table is smaller than might have been expected.

The fact that 1.7 percent of married women appear to be taking hypnotics regularly and for long periods of time confirms the view that the hypnotics problem is largely centred on this section of the population.

(j) How Many Repeats or Extended Supplies for Hypnotics and Tranquillisers are not Collected by Patients?

This is the other side of the coin.

Table XIX—1971: Prescriptions—Percentage of Prescriptions Ordering Repeats, etc., in which the Full Supply was Not Collected

	Rural Percent	Non-rural Percent	Total Percent
Hypnotics	2.0	4.3	4.0
Tranquillisers	8.3	6.2	6.5
Both	6.5	5.6	5.7

These figures are probably considerably lower than those for prescribing generally, but on the whole they point to a degree of unnecessary prescribing. In certain cases, however, a cauticus doctor may order a small supply plus a repeat, telling his patient that he may not need this further supply. Such a practice is to be commended.

(k) In 13 Years, What Effect (if any) has the Use of Tranquillisers had on the Prescribing of Hypnotics?

This is an interesting and important question. When a new tranquilliser is placed on the market, the manufacturers often claim that its use should lead to a reduction in hypnotic prescribing; and if tranquillisers do what they are claimed to do, this should obviously be one effect.

But it has already been shown that the *per capita* consumption of hypnotics has practically doubled in 13 years. Where do tranquillisers fit into the picture?

The problem was tackled by exploring the relationship between the level of hypnotic prescribing by different doctors, and their use of tranquillisers. If the claims of the tranquilliser proponents are true, then a low level of hypnotic prescribing should tend to be accompanied by a rather high level of tranquilliser use, and vice versa.

Doctors were grouped (a) as rural or non-rural, (b) according to the average numbers of hypnotic prescriptions issued per 100 forms.

Table XX—1971: Tranquilliser "Days" and Cost, by Number of Hypnotic Scripts per 100 Forms

Hypnotic Scripts per 100 Forms	Number of Doctors	Tranquillisers per 100 Forms (Average)	
		"Days"	Cost
Rural—			$
Nil	1	210	17.06
1–3	14	325	19.96
4–5	10	276	16.52
6–10	10	540	30.86
Average: 4.2 ..	35	372	$22.17
Non-rural—			$
Nil	6	268	13.16
1–3	35	444	26.94
4–5	30	491	31.47
6–8	42	488	26.85
9–18	37	700	40.20
Average: 6.2 ..	150	522	$30.54

It is obvious from this table that on the whole the more hypnotics a doctor prescribed, the greater was his use of tranquillisers. This was true both of rural and non-rural doctors. The fact is, therefore, that tranquillisers *as employed at present by most doctors* do not reduce the use of hypnotics, and this is borne out by the fact that the first decade of the tranquilliser boom has been accompanied by a doubling in the per capita use of hypnotics. Nevertheless, the qualification in italics in the last sentence is believed to be important.

(1) Legibility in Prescription Writing

In writing up the 1958 survey, it was recorded that of 168 doctors, there was only one whose prescriptions had to be rejected because they were impossible to read, and that "on the whole the standard of prescription writing was commendably high".

In the 1971 study each batch of prescriptions was classified for legibility on a six-point scale.

Of a total of 191 doctor batches, 6 were rejected. (Five were totally illegible. In the sixth the designations of patients could not be interpreted with confidence.)

The results, expressed as percentages, were as follows:

Legibility	Percent	
1. Very good	25	Good to very good 53 percent
2. Good	28	
3. Fair	19	
4. Poor	13	
5. Very bad	12	Very bad and illegible 15 percent
6. Illegible (rejected) ..	3	
	100	

One doctor in six or seven writes prescriptions so badly as to endanger his patients. In these days of potent medication and multiple brand names, many of which look alike, this is a disturbing observation.

IV. HOW MUCH WOULD BE ENOUGH?

Hypnotics have a place, and an important one, in general practice, but most authorities would support the view that on the whole, conscientious doctors with adequate time are likely to prescribe them less frequently than their overworked colleagues. By its own traditionally high standards, New Zealand is short of general practitioners, and it is probable that most of those included in this survey are in fact overworked.

Nevertheless, 7 doctors (3.8 percent) included no hypnotics in their samples of 100 prescription forms (averaging 184 prescriptions or 231 dispensings).

The next 49 doctors (14 rural, 35 non-rural)—26.5 percent—ordered from 1 to 3 hypnotic prescriptions per 100 forms. These men were all active, well-established practitioners. It is fair to contend that they set a standard which most, if not all practitioners, might be expected to match.

If all doctors prescribed like this 26.5 percent, the effect on the New Zealand figures would be:

(a) Percentage of population on an average night or day:

	Actual Percent	Possible Percent
Taking hypnotics	1.96	0.84
Taking tranquillisers	3.68	3.05
Taking either or both	5.0	3.22

(b) Cost per annum of hypnotics and tranquillisers:

Actual $(million)	Possible $(million)	Saving $
2.144	3.013	869,075

Such a saving would represent 29 percent of the annual bill for hypnotics and tranquillisers, or 1.3 percent of the total cost of pharmaceutical benefits. The saving on hypnotics alone would have been about $464,000, or 57 percent of the actual cost.

For reasons explained in note 2, these figures err on the low side.

Similar results were obtained in the 1958 survey*.

Many will agree with the writer's view, that the most important saving would have been in health and wellbeing.

V. DISCUSSION

When writing up the 1958 survey, preparatory to the 1971 study, the following comments were made:

> "Most doctors were prescribing hypnotics with more care than many people would have believed. About 25 percent prescribed them rarely, if at all. There were many instances of very cautious administration, prescriptions for less than half a dozen capsules at a time being not uncommon. Very lavish use of drugs appeared to be relatively rare.
>
> "An interesting discovery was that married women (or separated, widowed or divorced) were getting almost exactly twice as many prescriptions of any kind as were adult males. They were also getting twice as many 'sleep prescriptions' . . .
>
> "Do married women really need all these hypnotics—more than twice as many as their husbands? It looks as if the doctor's habitual pattern of prescribing may be a factor; married women consume more medicines of all kinds than men, and get their hypnotics thrown in. Could the situation be related, perhaps, to the dull kind of life lived by so many housewives in 1958—and if so, have the considerable changes since then (e.g., in the proportion of working wives) made any difference?
>
> "A hypnotic dose of any barbiturate is an effective anaphrodisiac. The most popular hypnotics were those classed (at that time) as medium or long-acting†, and barbiturates are to some extent cumulative in effect. One wonders how much of the lack of enthusiasm for sex which is said to be a common factor in marital disharmony is due to the habitual or excessive consumption of hypnotics by married women in this country."

Against this background, the findings of the 1971 survey are startling and depressing. Despite the social changes mentioned above, despite the fact that on an average day 3.7 percent of the population and 8.3 percent of married women take a tranquilliser, the use of hypnotics generally has increased by 78 percent, and married women have almost doubled

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*Nine percent of doctors ordered no hypnotics. If all had prescribed like the next most conservative 25 percent, there would have been a saving of $140,000 in a total hypnotics bill of $210,000—about 67 percent.

†It has since been recognised that individual reactions vary considerably. Nevertheless, it is undeniable that on the average quinalbarbitone (Seconal)—6 percent of sleep scripts—is more rapidly eliminated than the other four hypnotics which surpassed it in popularity, and together made up 82 percent of sleep scripts.

their consumption. On an average day, about one married woman in eight takes a hypnotic, a tranquilliser, or both, and 1.7 percent are taking hypnotics regularly and for long periods of time. True, the non-barbiturates have gained in popularity, but as 44 percent of the hypnotics consumed in 1971 were still barbiturates, the use of barbiturates has not in fact declined to any very marked degree (about 22 percent).

The most popular hypnotic in 1971 was Mogadon, and the two most-widely used tranquillisers were Valium and Librium. Chemically and pharmacologically they are closely related, and all three were introduced by the same firm. Contemporary critics of the widespread use of psychotropics drugs [6,7] sometimes draw attention to this fact as if it were in some way to the discredit of the firm or its products. This is nonsensical and unfair. These particular drugs are amongst the safest in their class, even in gross overdosage, and there appears to be little or no evidence that they ever lead to physical dependency. Although closely related, clinically they differ in their effects, and one or other suits some patients better than the others. Inquiries carried out a few years ago at the request of the Pharmacology and Therapeutics Advisory Committee elicited a formidable body of informed opinion in favour of Librium as a pharmacological agent in general practice.

The only valid criticism of this situation is that doctors place too much reliance on these particular drugs and use them to excess; and this in turn may be traced to overzealous promotion by the firm.

But in today's fiercely competitive market almost any new drug, however valuable, must be vigorously promoted if it is to find a place in medical practice. It is for the doctor to apply his judgement and commonsense in this as in other clinical matters. Promotion is a hard fact of life, and doctors must learn to cope with it.

A much more disturbing observation is that one year after a sharp warning about the disadvantages of Mandrax as a hypnotic was mailed to every doctor in New Zealand, 39 percent of doctors were still prescribing it; in fact it was the third most popular of hypnotics. Here, indeed, is a good example of the triumph of promotion over good sense.

Hypnotics being used at double the level of 13 years ago; tranquillisers disappearing down our throats to the tune of $\$2\frac{1}{3}$ million a year; what excuse can there be for such a situation in a country like New Zealand?—except shortage of doctors and lack of time to spend on sorting out psychological troubles.

One thing seems to be clear. For many women in New Zealand marriage is a stressful occupation, which is getting worse instead of better.

Hypnotics and tranquillisers are not the answer.

NOTES

Note 1—Method of Sampling

(a) *1958 Survey*—The aim was to examine 2.5 percent of all prescriptions written in or about July 1958, in proportion to the numbers submitted from each of the four pricing office areas. Mixed bundles of prescriptions were called for from every tenth doctor in an alphabetical list of doctors for each area, who had received not less than £2,000 in the previous year for general medical services. These lists included a few specialists, and some general practitioners with specialist interests.

(b) *1971 Survey*—The list of doctors from which the sample was drawn was confined to general practitioners (without any known specialist interests) who had received not less than $4,000 for general medcial services in the year 1970–71. A random sample totalling 198 was drawn, each of the 15 health districts which handle general medical services claims being represented in proportion to the number of active general practitioners in each area. The whole of New Zealand was covered in this way. For each doctor, a batch of 100 prescription forms issued in or about July 1971 was examined. The total number of batches received was 191*, of which 6 were rejected as illegible. The remaining 185 doctors were classified into those serving designated rural areas (35 doctors); towns with 5,000-20,000 population (35 doctors), and cities (115 doctors). In the case of the designated rural areas, the population served (531,000) amounted to about 19 percent of the New Zealand total, and the 35 doctors constituted 19 percent of the sample.

Note 2—Barbiturate Prescribing in New Zealand

Dempster and White,[4] and Bamford,[5] in studies of the Dunedin Pricing Office area in 1952 and 1955, found that about 7.9 percent of prescriptions were for barbiturates. On the basis of data from the 1958 study, 7.9 percent for the Dunedin area would correspond to 9.6 percent for the Dominion as a whole. This is almost identical with Dunlop's figures (9.4 percent) for England in 1952.[1]

In the Dunedin studies there was no significant difference between the percentage of barbiturate prescriptions in 1952 (7.8 percent) and 1955 (8.0 percent). In each case, separate figures were given for February, May, and August. The percentage was lowest in August, presumably because the higher prevalence of winter ills in that month swelled the prescribing of other drugs:

	Percentage of Barbiturate Prescriptions		
	1952	1955	Both Together
	Percent	Percent	Percent
February	8.6	8.4	8.5
May	8.2	8.8	8.4
August	6.6	7.1	6.9
	7.8	8.0	7.9

These figures suggest that attempts to calculate annual figures for the use of barbiturates or related drugs, from percentages observed in August (or July, as in the present survey) are likely to give results around 14.5 percent below the actual annual totals.

Another approach suggests a still wider margin. In the following table the Department of Health's figures for annual expenditure on hypnotics and tranquillisers in the 2 preceding years are compared with the estimates in this paper based on the July 1971 survey. (See page 180.)

*For various reasons, samples were not obtainable for 7 doctors.

Annual Expenditure	Official Returns Year ending 31 March 1970	1971	Estimate, Survey July 1971
	$	$	$
Hypnotics	580,600	790,300	811,500*
Tranquillisers ..	2,812,900	3,028,700	2,356,000
Both	3,393,500	3,819,000	3,167,500

The estimated total based on the July 1971 survey is 17.1 percent below the actual total for 1970-71, and 6.7 percent below that for the previous year.

All figures for annual estimates given in this paper must, therefore, be regarded as conservative. They probably understate the actual situation by at least 15 percent.

Note 3—Drugs Included in Survey

These are listed on pages 178 and 179. Three brand-name hypnotics and seven tranquillisers, although included in the Drug Tariff, were not encountered in this survey. Two of the latter were "Hospital Board (Specialist)" drugs, which are not obtainable through chemists, and so would not have been included in the prescription batches used in this survey. This restriction severely limits their use in general practice.

Note 4—Claims, Prescriptions, and Forms

In New Zealand, unless the doctor directs otherwise, extended supply prescriptions are dispensed in monthly lots, and each is counted as a prescription, as it is the subject of a separate claim. A prescription ordering a repeat is similarly counted twice.

The New Zealand official figures for "prescriptions", therefore, relate to "claims" or "dispensings", rather than to prescriptions in the usually accepted sense. The official figures are swelled still further by the inclusion of bulk orders—medical practitioners', midwifery orders and bulk supplies for private hospitals.

In the 1971 survey it was found that:

(a) To convert "claims" to prescriptions, divide by 1.26.

(b) To convert prescriptions to prescription forms, divide by 1.84.

The official total of "prescriptions and orders" (meaning claims) must first, of course, be reduced by the number of orders supplied (about 40,000 in 1971–72).

It is necessary to point out, however, that prescriptions issued through hospital board dispensaries are not included in the official total. No hypnotics, and only two minor tranquillisers fell into this class, both being "Hospital Board (Specialist)".

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*This estimate for hypnotics is only 2.7 percent higher than the preceding year's total. The latter year, however, showed a 36 percent increase. Obviously the estimate falls far short of the expected figure.

APPENDIX XIII

TREATMENT AND MANAGEMENT—SOME INDIVIDUAL VIEWS

At the time of its deliberations the committee had before it reports of members who had had the opportunity of visiting a number of drug treatment facilities in North America and the United Kingdom and of a medical officer of health who had been asked to undertake a comparable visitation in the London area for the furtherance of the work of the committee.

The committee also invited views and comments on treatment and management aspects of drug misuse from a number of medical practitioners having specialist qualifications in the broad field of psychological medicine. A number of these medical practitioners had already made personal submissions at meetings of the committee in Auckland, Wellington, Christchurch, and Dunedin and the committee was concerned to have some written exposition, with as wide a range of viewpoints as possible, not only for its own information but also to serve as a corpus of opinion and experience during its deliberations on the important area of treatment and management and the consequences of drug misuse of the persons so involved.

The material submitted in writing to the committee covered a wide range of viewpoints and observations based on experience, and some parts of these submissions have been drawn upon for the purposes of various sections of this report. It did, however, occur to the committee that the inclusion of several of the submissions in whole, or in part where covered elsewhere, would be of interest. Of necessity there has been some occasional editorial condensation to meet limitations of space.

NOTE—The views expressed in this appendix are those of individual writers and do not necessarily represent the views of the committee.

1. VIEWS ON VISITS TO TREATMENT FACILITIES OVERSEAS

(a) PROFESSOR A. JOAN METGE DEPARTMENT OF ANTHROPOLOGY, VICTORIA UNIVERSITY OF WELLINGTON

Observations Arising from Visits to Some Treatment Facilities in North America and Great Britain 1970–71

Introduction

While overseas on sabbatical leave between 1 October 1970 and 31 May 1971, I took the opportunity to visit organisations engaged in the study and treatment of drug users in and between the cities in North America and Great Britain to which my academic interests took me. Because this was not the primary purpose of my trip, I was unable to observe the daily working of these organisations over a period of time but I talked at length with a wide range of both staff and patients. In this way I visited the Narcotics Addiction Foundation in Vancouver (1½ days at the main methadone treatment centre, 1 day and 2 evenings at the detached centre for non-opiate users); Cool-Aid

(a young people's service and counselling organisation) in Victoria; the Illinois Drug Abuse Program in Chicago (1 day); the Ontario Alcohol and Drug Addiction Research Foundation (4 days) and Oolagen in Toronto; the headquarters of the Canadian Commission of Enquiry into the Non-medical Use of Drugs in Ottawa (2 days); in London the Ministry of Health, the Home Office (Drug Section), the psychiatric clinics for the treatment of drug users at Charing Cross Hospital and St. Giles Centre, the Maudsley Addiction Research Unit, the National Addiction Research Institute (C.U.R.E.), the Camberwell Community Drug Project Day Centre, the Institute of Drug Dependency, the Church of England Council for Social Aid, and Release; and in Edinburgh, the Chief Medical Officer of Health and Dr Matthews of the Royal Infirmary.

These visits were undertaken on my own initiative and were not subject to either direction or financial support from the Committee on Drug Dependency and Drug Abuse, the Department of Health, or any other source.

At intervals during my leave I sent back to my colleagues on the Committee on Drug Dependency and Drug Abuse a detailed account (comprising over 70 pages) of what I saw and learnt, together with a large collection of pamphlets and other literature. Here I shall attempt to summarise the main themes of my experience under a limited number of headings.

The Size of the Problem

The New Zealand visitor to North America and the United Kingdom is staggered by the magnitude of the numbers involved in the non-medical use of drugs and the number and size of organisations dealing with some aspects of it. For instance, in 1970–71, the number of heroin "addicts" was estimated at over 4,000 in Canada (by the Le Dain Commission interim report: p. 321), and between 1,200 and 1,400 in the United Kingdom (by the Home Office). The Ontario Alcohol and Drug Addiction Research Foundation had a staff of over 700 distributed between 20 local units, and there were numerous other organisations in the province. But large though the total numbers were by New Zealand standards, they were comparatively low when reckoned as percentages of the immense populations of these countries, or compared with the percentage involved in alcoholism.

In both Canada and the United Kingdom, the main focus of concern and attention was on heroin dependence, with its concomitants of organised distribution and resort to crime for finance. However, the existence and needs of young people engaged in multiple drug use were attracting increasing attention.

Variety of Approaches

Without exception those I talked to emphasised the need to use a variety of approaches in the treatment of drug dependence and drug misuse. There was no single answer (they said), because there was no single problem. On the one side, there was a variety of drugs with differing effects, on the other, users with varying personality types and backgrounds, varying degrees of involvement, and varying reasons for becoming and remaining involved. The personal reaction of a patient

to a particular treatment unit, programme, or staff member was a crucial factor in success or failure. What suited one patient failed to help another with an apparently similar problem or background.

Typically the treatment agencies I visited combined several different treatment methods in each programme, for instance, methadone maintenance with personal counselling and/or group therapy, and most offered several different programmes, either in units that were physically separate or increasingly in the same unit. The two largest institutions visited, the Illinois Drug Abuse Program in Chicago and the Ontario Alcoholism and Drug Addiction Research Foundation in Toronto administered a wide variety of programmes and units.

At the beginning of 1971 the Illinois Drug Abuse Program (which had 1,000 patients in treatment and 1,000 on the waiting list) was operating the following units:

(1) Several pre-treatment holding units based on a dispensary providing methadone medication only while patients waited entry to a more comprehensive unit;

(2) Four out-patient methadone clinics supplying methadone plus weekly group therapy, and four similar clinics with variations;

(3) Two in-residence multi-method centres which catered for (a) methadone support patients needing a highly structured setting for a limited period, (b) cyclaxocine patients, and (c) patients who had elected rapid withdrawal followed by establishment on a drug free regimen, (d) provided emergency treatment for program members and (e) in one case, group therapy for out-patients;

(4) A half-way house for advanced patients from various treatment settings where group therapy was progressively de-emphasised as patients learnt to operate effectively on their own "outside";

(5) Three in-residence long-term drug-free communities for both heroin and non-heroin patients, which emphasised abstinence, the restructuring of character, and progression through stages of living and working first in and then outside the community;

(6) A re-entry clinic for those who had broken off treatment in other units but wanted to try again; and

(7) Two experimental units dealing with non-heroin users.

In late 1970 the Ontario Alcohol and Drug Addiction Research Foundation provided in the Toronto Metropolitan Region alone: (1) four district stations serving their local communities in a variety of ways—for opiate users; (2) a detoxification centre and (3) a methadone treatment centre—for alcoholics; (4) a residential treatment centre and (5) a half-way house; (6) a farm providing a drug-free environment away from the city; and (7) a multi-service centre including a medical clinic for young drug-users of all kinds.

Small-scale Informal Units

This emphasis on "multi-modality" (as the Illinois Drug Abuse Program calls it) was closely associated with a preference for small, decentralised informal and highly personal units as against large-scale centralised institutions, especially hospitals. The drug users dealt with typically lived in the poorer parts of the city, and were both short of

money and in revolt against materialism and authoritarianism. They were far more likely to visit a treatment unit on their own initiative if it was in their own area, in an old house with shabby furniture and staff in plain clothes. In general, also they reported feelings of loneliness, boredom, and alieniation from mass society, and had difficulties in handling personal relations. Experience had proved that interaction with a small group of therapists and other patients in a relaxed and homely atmosphere was of key importance for the successful handling of their problems. The units of the Illinois Drug Abuse Programme were "designed to be comfortable and to foster the feeling that they belonged to the patients . . . The size of the patient population at any given unit was kept small enough to permit a sense of group identity". Small units also had the advantage that they could make adjustments and modify or switch functions much more quickly and easily than large ones, an important consideration in view of the rapidity with which patterns of drug use and the associated problems changed.

The Team Approach

The idea that the treatment of drug users was primarily a matter for doctors was rapidly giving way to emphasis upon a team approach, involving co-operation and sharing of responsibility between doctors and other workers. The treatment organisations I visited not only included social workers, psychologists, and psychiatric nurses in treatment teams but were increasingly giving non-medical personnel equality of status with the doctors. In the new Institute for the Clinical Study of Addiction planned by the Ontario Addiction Research Foundation (and opened in May 1971 after my visit) the director of the outpatients clinic was a social worker, and the primary therapeutic role in each patient's case was assigned to the appropriate team member on the basis of the patient's needs, so that it might or might not be a doctor. In Canada in particular, major emphasis was placed on counselling and group therapy. Moreover, these involved working not only with individual patient and with groups of patients, but also with the patient and his family. As with alcoholism, it was increasingly appreciated that the roots of the patient's problems lay not in himself alone but in his interaction with others in his intimate circle. Counsellors involved in this sort of work spent at least part of their time away from the treatment unit visiting patients in their own settings. Again, especially in Canada, many organisations employed "detached" social workers who frequented coffee bars and places where young people congregated in order to contact and offer help to young drug users. As such workers became personally known they were often approached by those wanting treatment.

Non-official Aid and Treatment Groups

One of the features of the treatment scene in both North America and the United Kingdom was the proliferation of relatively small-scale, highly personalised aid and treatment groups set up outside the established and officially sponsored social and medical organisations. (The Le Dain Commission referred to them as "the innovative services", a title I have avoided as rather misleading, since innovation was not their major feature, nor confined to them.) These groups typically began "at street level", in a small, informal and relatively instructured

way in direct response to particular needs and particular situations, and their staffs included a high proportion of workers who had had direct experience of the non-medical use of drugs but little or no training in social work. Their backing, moral and financial, was mainly from unofficial private sources and voluntary bodies. While alike in these respects, the groups varied widely in scale, methods and the services they provided, which might involve any or several of the following: emergency aid for bad trips, overdoses, and other acute problems; temporary and permanent accommodation; individual and/or group therapy; advice on and referral to specialist services; in-residence treatment and retraining for a defined period, leading to return to full participation in outside society (for example Oolagen and Phoenix House); or a permanent supportive community in which members found a permanent integrated way of life (for example X Kalay in Vancouver.) Individual groups often had a limited life span, folding up when the need which generated them had passed or problems proved too great; but at least some were still going strong after 5 years or more. For their first 2 or 3 years such groups were highly flexible, organisation being based on the personal friendship and interaction of a limited number of staff members, instead of a formal structure through which workers passed. Typically each group had a highly distinctive flavour or ethos derived from the personalities and ideals of its leaders. This combination of flexibility and uniqueness seemed to be a key factor in the relative success of some of these ventures compared with more formal official ones. Success, however, was usually followed by expansion, formalisation, and codification of the ethos. In some cases, this proved fatal, but others overcame the problem by budding off or daughter groups; there are for instance several Phoenix Houses, including one in London.

Two examples of "innovative services" which I found impressive were Cool-Aid in Victoria and Oolagen in Toronto.

Cool-Aid in Victoria was started by the Victoria Youth Council in 1968 to meet the needs of the young transients who flock to British Columbia in the summer. In December 1970 it had its headquarters in an old house where staff provided a 24-hour counselling service and temporary hostel accommodation for 15 girls. Up to 60 boys were accommodated and meals served in a nearby church basement. (In 1971 Cool-Aid transferred its activities to a converted church complex). Cool-Aid was "run" by the Victoria Chapter of the Pacific Community Self-development Society, a registered society, in that it was responsible for handling and auditing all monies, making final decisions and supervising the staff. But the chapter kept well in the background, and the day-to-day management of Cool-Aid activities was in the hands of four full-time staff members all under 25 assisted by about 20 part-time voluntary helpers. In a real sense, Cool-Aid was "run by kids for kids . . . it is a group of kids trying to be their brothers' keepers". In 1970 Cool-Aid staff handled about a hundred counselling and referral cases a month. These included many problems besides drug use, but the latter was often intertwined with the others. They maintained a roster of 28 couples available to billet young people and another of professional consultants, consisting of 18 physicians, 12 dentists, 5 psychologists, 4 lawyers, 1 dental mechanic, and 1 optician (who gave their services free of charge where necessary). They had also

built up personal contacts with staff members of Government departments in order to ensure sympathetic treatment for any cases referred to them.

Oolagen grew out of the concern of one young man for the highly disturbed young amphetamine users in the central city and his conviction that they needed highly individual attention. Registered as a non-profit-making organisation, Oolagen was supported financially by contributions from municipal authorities, churches, and charitable organisations and administered by a 12-member board of trustees. In a typical Toronto house of three storeys and a basement, it provided resident places for three boys and three girls, and a lounge and dining room which served a stream of young people looking for advice or company. The staff of eight full-time workers, operating a roster with a 24-hour coverage, worked mainly with the residents but maintained regular contact with ex-residents who had moved into rooms on their own and gave visitors what help they could. Residents (who were often referred by social agencies) were accepted only if they were willing to accept the house rules (no dope, no sex, no liquor, no weapons) and to attempt to change their life style. Each was helped by an individual therapist to develop a daily routine and a positive plan of action: returning to school, taking correspondence or night classes, or going to work. Residents shared the household chores and became involved in "an ongoing community life, accounting to and responsible for each other". Three group therapy sessions were held each week, but much of the needed learning and growing proceeded through individual and group interaction.

Those with experience of non-official services of this kind from within and without stressed the importance of allowing them to maintain their autonomy and the freedom to experiment and even run risks, because they were able to get through to and meet the needs of individuals who would avoid other help until in serious difficulties, and because they often pioneered new and effective treatment procedures.

However varied their own work, I found that the official institutions, instead of actively resenting, co-operated with the smaller private and innovative treatment units whether they provided similar or different services, because they widened the choice of facilities available. In the metropolitan areas of Vancouver, Toronto, Chicago, and London, official and private treatment bodies were effectively linked by informal networks of personal contact and inter-referral, and sometimes in formal liaison organisations.

Involvement of Ex-drug Users in Treatment

In Canada, Chicago, and the United Kingdom, I found that ex-drug users were widely involved in treatment, research, and education, not only in the non-official services (which often arose from their initiative) but also in official organisations. They had knowledge and understanding which made them able to communicate with current users more successfully than professional workers and to contribute invaluable insights to the discussion of cases in a treatment team. It was also recognised that involvement in helping others was of therapeutic value to the individual. The Addiction Prevention Programme of the Narcotics Addiction Foundation in Vancouver involved those who

came there for help in the centre's programme as "voluntary workers" as soon as they reached a certain stage of development. As such they attended in support of the staff members on duty and did a certain amount of visiting under supervision. In this way they came to have a vested interest in the achievement of the centre's goals.

Use of Methadone in Treatment

In all the units treating drug dependence which I visited, the prescription of methadone had a recognised place, but staff insisted that it should be used only in conjunction with other forms of treatment and for certain kinds of patients. Methadone was used in three main contexts: (1) in rapidly decreasing doses over a short period of time (3–12 weeks) as part of a programme of short-term withdrawal; (2) in high dosage as a "blockade" against the effects of heroin, over a more or less lengthy period ("high" methadone management); and (3) in a lower dosage sufficient to keep the patient in a state of reasonable physical and psychological comfort, over a more or less lengthy period ("low" methadone management). In the case of both high and low methadone management programmes, the idea was to "stabilise" the patient at a certain level for a reasonably long period of time during which he was helped, through regular contact with members of the treatment team, to develop his capacity for coping with life, especially with problems of accommodation, employment, and personal relations. It was generally agreed that the ultimate aim should be to eliminate the prescription of methadone and establish the patients in a drug free way of life. In practice however this proved difficult to achieve in many cases and situations. Some patients whose dependence was particularly deep and long standing seemed genuinely unable to achieve adjustment to life without medication. Many more resisted the idea. In large cities where both the illicit supplies of heroin and opportunities for making money to buy it by crime were plentiful, cutting back a patient's methadone dose level almost invariably led to his return to illicit use and crime unless he was strongly motivated towards abstinence. In such circumstances, it was argued, maintaining patients on methadone indefinitely, while not the ideal answer, at least effected a substantial reduction in unemployment, illegal drug use, and crime. (The Narcotics Addiction Foundation reported in its annual report 1971 that 76 percent of those stabilised on methadone had used little or no heroin in the past year, 60 percent of the employable were in employment, and 66 percent had not been charged with crimes.) However, many of the workers I spoke to were deeply concerned about the dependence producing effects of methadone itself. They were haunted by the fear of turning an incipient dependence into a full blown one and worried that stabilising patients on methadone seemed in many cases to reinforce rather than diminish their reluctance to contemplate eventual withdrawal.

I found almost unanimous agreement on the following guidelines for methadone management programmes. First, the right to prescribe methadone for dependence on narcotics should be limited to doctors with special knowledge and experience working in approved treatment units in association with non-medical team mates. Secondly, its prescription should be limited to patients whose dependence on

narcotics had been established, by standard procedures and preferably in a hospital setting, to be both deep and of long standing, 2 years of regular use being the period commonly stipulated as the minimum. Except in special cases it should not be prescribed for anyone under 18 and preferably not under 20. Thirdly, methadone should be provided in liquid form and for at least 2 to 3 months patients should be required to pick it up and drink it on the treatment premises daily. The right to "carry" sufficient for 2 to 3 days, but never more, should be awarded only after clear evidence of reliability and good faith. Fourthly, regular checks should be made for the use of other drugs, with a standard set of disciplinary procedures for lapses. Fifthly, methadone should always be combined with complementary forms of treatment involving intensive personal contact with therapists and social workers.

Recording and Evaluation

All the treatment units I visited emphasised the vital importance of building effective methods of recording and evaluation into all treatment programmes. In a field where success rates were typically low, it was essential to identify those which achieved better results and to analyse the reasons. Too often evaluation and comparison had been vitiated by different methods of assessing "success" and the practice of taking account only of those currently in treatment. For proper evaluation of programmes it was important to keep data on those who only inquired, on those who dropped out during treatment and on those discharged after completing treatment. Where possible, inquiry should be made into the reasons for patients dropping out or continuing in a programme: the relative success or failure of treatment in particular cases could not necessarily be attributed to the treatment programme. Problems abounded in collecting this data. Doctors and therapists were often too busy dealing with distressed individuals to record the necessary details. Ex-patients were difficult to trace because of a mobile life style, return to illicit drug use, or an understandable desire to leave that period of their lives behind them. It was, therefore, advisable to entrust this task to a staff member outside the treatment team.

Information Centres

Workers in the drug treatment field also stressed the need to provide for the collection and collation of up-to-date information on drug misuse and treatment in a centre where it could be quickly retrieved by treatment workers, educators, and inquirers. In Canada this service was provided by branches of the large-scale organisations such as the Narcotics Addiction Foundation and the Ontario Addiction Research Foundation. In England it was provided by an independent body, the Institute of Drug Dependency in London.

Penal Sanctions

Among those engaged in the treatment of drug dependency, I found a growing conviction that the cost of penal sanctions on drug misuse was too high compared with what they achieved. They were costly, first, in terms of personal suffering to the users and their

families, driving the former further into alienation, resentment, and psycho-pathology, and often also into deeper involvement with drugs and crime. In penal institutions, individuals whose lawbreaking had been confined to drug use came into contact with criminals of other kinds and were instructed in criminal attitudes and methods. Penal sanctions interfered seriously with drug users seeking help from treatment centres. They tied up police officers' time, hospital beds, and accommodation in penal institutions. Yet they were not in fact effective in preventing people becoming involved or continuing in drug misuse: the compulsions towards drug misuse were stronger than sentences that non-users would consider a deterrent.

Preventive Measures

Aware of the difficulties of treating drug dependence once it has developed, treatment workers stressed the priority of preventive measures, with special reference to education of the general public in sensible attitudes to drugs and drug misusers. In Toronto the district sections of the Addiction Research Foundation had in the previous 2 years reoriented their attitudes and activities from working in a patient-oriented environment at the station itself to reaching out to and getting involved in the wider community. At the central station, two staff members had been officially designated "community consultants", and all staff members were involved in some particular community project, either working regularly with some community agency or as consultants, for instance, to guidance departments at secondary schools. The station staff organised periodic one or two day seminars to which they invited staff from other social agencies to keep them informed on new developments. They also offered regular consultant and resource services. As a senior staff member put it: "Our aim is to make people in the community feel comfortable about dealing with the drug problem just like any other problem, and to show them that they can cope themselves with all but the most difficult cases".

In North America, the large official organisations all spent a substantial proportion of their budget on education sections. I was particularly impressed by the policy and productions of the Ontario Addiction Research Foundation, which insists on providing sound well researched information free of judgments, speaking from a scientific base, and encouraging people to think the issues through for themselves. Its education section not only produces a wide range of literature designed to reach different sections of the population through a variety of channels, it also sponsors extensive educational programmes in the schools and runs several residential summer courses each year on "alcohol and other drugs of dependence", where those actively engaged in the field—doctors, nurses, social workers, teachers, ministers—mutually educate each other in small interdisciplinary discussion groups.

Conclusion

I found the opportunity to see something of what was happening in the area of drug misuse and treatment overseas and to talk to some of those directly involved enlightening, stimulating, and of direct

relevance to New Zealand. While the situation here differs in some important respects from that in the countries I visited so that direct extrapolation is to be avoided, there is a great deal we could profitably learn from their experience. I should sincerely hope that arrangements can be made to do this on a personal basis, by sending New Zealand workers overseas for a period to work with selected organisations, and by attracting overseas workers here in exchange or to attend interdisciplinary conferences.

December 1971.

(b) Dr N. T. Barnett, Medical Officer of Health, Auckland

Some Aspects of Drug Misuse in the United Kingdom (1971)

Besides being part of my own programme for the WHO Fellowship I was asked by Head Office during my last week's stay in Britain to visit some drug treatment centres in the United Kingdom. I included in this study an overall view of the whole problem as drug treatment centres appear to me to be a small, albeit very important, aspect of Britain's approach to the issue. This is commonly, and erroneously referred to as the "British system" which makes the blood of our British colleagues change almost to magenta and I feel not without a certain amount of justification.

Taking an overall, detached, and almost a layman's view of the problem as I saw it in the United Kingdom, it appeared that the whole problem of drug use and abuse was basically no different from anywhere else except that obviously it is on a relatively larger scale than in New Zealand. Much of this of course I feel stems from the very obvious fact that by virtue of their geographical proximity to the Continent, which whilst being a great boost to the economy in the way of attracting tourist trade, has built-in disadvantages, one of which is drug-trafficking. Combined with this is the escalation of the extra-permissive and bohemian society which has virtually taken over the Oxford Street, Oxford Circus, and Regent Street area with its open headquarters under the statue of Eros in Piccadilly Circus.

It is hardly worth repeating here that the two main problems on the horizon of the drug scene are:

1. The use of marijuana.
2. The use or abuse of narcotics and psychotropic drugs as distinct from marijuana.

I was fortunate enough to see the application of the current British policy and the part voluntary or quasi-Government organisations were playing in an attempt to deal with this problem. I say deal rather than solve advisedly because in my humble opinion the only long-term prospect of solution to the problem lies in the sociological, as much as the medical field. Co-ordinating sociological and medical approaches, combined with more intensive health education in all aspects of family and healthy living is needed at a very early stage, even to the extent of talks to expectant mothers at antenatal sessions because in my view every unborn child is potentially a prospective addict. Indeed if the mother is on "hard" narcotics the newborn infant may start life with withdrawal symptoms.

The areas I visited can be divided roughly into two parts:

1. *Therapeutic*—This is the "ambulance at the bottom of the cliff" to use an overworked cliché but it seems adequately to describe the place of this aspect of the problem.

I refer of course to the treatment centres I visited which included:

1. Austin House, St. George's Hospital, Tooting Bec.
2. Lambeth Clinic which is part of Lambeth Hospital.
3. Queen Mary's Hospital, Roehampton Lane.

There are 11 other such centres which I did not have time to visit but all of which operate on a similar system to that which I will describe, the policy having been laid down by the Home Office through the British Ministry of Health.

Besides this there are four or five in-patient units one of which I visited at Tooting Bec Hospital with the consultant psychiatrist Dr Tom Bewley.

2. *Supportive*—These include community orientated places run and staffed by interested persons. Some are financed by voluntary support while others are financed from several sources including local authority and Ministry of Health.

The places I visited were:

1. Release.
2. Phoenix House (Featherstone Lodge).
3. Burnett Hall.
4. New Horizon Youth Centre.
5. Institute for the Study of Drug Dependence.
6. Research Unit for Student Problems.

In addition I had discussions with personnel from the Drug Section of the Home Office including the statistician in charge of records and the chief inspector for drug control.

Visits to Treatment Centres in the London Area

1. Queen Mary's Hospital—Roehampton.
2. Austin House—St. George's Hospital, Tooting Bec.
3. Lambeth Clinic—Lambeth Hospital.

All clinics operate on the same basis in line with the policy laid down by the Home Office.

Premises

Structurally these varied from clinic to clinic though all had accommodation for one or more psychiatrists, a social worker, a nursing sister, and clerical staff as well as the usual waiting rooms, toilets, and interviewing rooms.

Staff

The basic minimum staff consists of a psychiatrist, who is usually part-time, a qualified social worker, a nursing sister, and a clerical officer.

I might add here that the social worker at a treatment centre is a most important member of the team as she acts as the liaison between the patient and the centre. She must be available at all times,

particularly in cases of crises. If time permits she also does a certain amount of home visiting but shortage of staff does not often permit this.

Referrals

Patients are referred from various sources including: the general practitioner; probation service; friends already in the centre; and casualty departments.

Procedure

Cases first report to the office where details such as name and address are taken. They are then seen by the social worker who takes a detailed social history. The psychiatrist then interviews them and takes a complete clinical history and does a physical examination. A urine specimen is taken and the patient is given an appointment to return in a week's time when the results of the urine specimen will have been received. If the case appears to be a genuine one, for instance, if the patient appears to be a "true addict", therapy is commenced, the main objective being to wean him off heroin on to methadone and hopefully to get him off narcotics altogether if possible. This, according to Dr Lyons of the Queen Mary's Clinic, is not an easy procedure as patients often "score" (they get drugs from other sources). Some cases may require hospitalisation but as only a few beds are available for this purpose only a limited number can be admitted.

The patient is given a prescription on a standard form. This entitles him to a week's supply of drugs which must be *picked up daily* except for the weekends when he can get 2 days' supply.

Cases seen by the clinic are reported to the Home Office where their names are entered on a "register" in case they attempt to visit various clinics to obtain additional supplies of drugs.

Dr Lyons of Queen Mary's Clinic stressed that users should be distinguished from "true addicts" who get withdrawal symptoms and are also psychologically dependent. The prognosis is good if the addict comes in the early stages of his addiction. Getting off the drug is not as difficult as dealing with the basic personality problem and the majority of junkies, in his view, have poor personalities. He stressed the dangers of barbiturate users if they inject themselves intravenously as they are likely to get abscesses. Unconsciousness is always likely.

Fixing, he thinks, is a community ritual. He feels that the majority of drug users will not remain on drugs but some of those with weak personalities are likely to continue. A disturbing percentage of school children have experienced drugs of some sort, though not commonly hard narcotics.

Once the addict is accepted by the clinic he is seen each week by a psychiatrist when he receives a certain amount of counselling and, depending on his progress, his maintenance dose is adjusted and his prescription renewed and altered if necessary.

One patient at the St. George's Clinic appeared to be rather aggressive towards the psychiatrist initially but subsequently apologised. Asked his opinion of the value of treatment centres he said he felt that they were a good thing as the addict was forced to keep on the dosage of drug prescribed.

At Lambeth the psychiatrist interviewed three patients. One was a hardy Scot who felt that his supply of heroin was inadequate and, as a result, he had to resort to the "black market" and was subsequently "busted" by the police. He now wished to be admitted to hospital as he wanted to get off drugs. The psychiatrist decided that this was not a genuine reason and that the Scot was trying to evade police proceedings.

Inpatient Treatment

There are relatively few inpatient units. I visited the one at Tooting Bec with Dr Bewley the consulting psychiatrist. This unit, within the grounds of the hospital, was completely self-contained. The front door was always kept locked.

Patients are admitted here on the recommendation of their own doctor or through outpatients. Reasons for admission were mainly for general medical reasons or if the addict was unable to cope with his maintenance dose.

Some patients are let out on parole but must return to the hospital each night. There are strict penalties in the way of denial of privileges if this parole is broken.

Research Unit for Student Problems—London University

Dr Nicholas Malleson is physician in charge, University of London, Central Institutes Student Health Service, and also a member of the Standing Advisory Committee on Drug Dependence.

Apart from discussing drug usage on a broad basis Dr Malleson did not particularly commit himself on the current situation in the United Kingdom other than to mention the present system.

The Chelsea Drug Addiction and Research Unit

Under the direction of Dr Chapple, consultant psychiatrist.

The centre is located in an old building with the word CURE written on the door. The lower floor is Dr Chapple's office and the nurse's office, reception desk, and secretary's office. The next floor has two rooms, one for meetings and the other for art and craft work.

The institute was first formed in January 1967 and was known as the Chelsea Addiction and Research Centre. Dr Chapple who has been treating narcotic addicts in the hospital situation, was disturbed at the high rate of relapse on discharge and considered it was necessary also to rehabilitate the addict in his own home surroundings, where despite temptation he had the support and sympathy of a team of skilled workers in time of stress.

The addiction work grew so rapidly and the needs became so great that in July 1968 a council was set up consisting of a group of doctors, lawyers, social workers and business men and the National Addiction and Research Unit was registered with the Charity Commissioners.

In 1968 a joint committee was set up with the National Association of Youth Clubs and the Maudsley Addiction Research Institute.

In December 1969 Dr Chapple became virtually whole time with the institute. The Home Office provided a research worker to work with the medical director and the institute acquired independent premises at 533A Kings Road in 1970.

The centre, though an independent unit, receives some financial assistance from the Home Office on an ad hoc basis. Local authorities provide a cash grant for addicts from their particular area. The council of the unit is elected from the ranks of businessmen, doctors, magistrates, etc. There appears to be a good liaison with the courts, probation service, and magistrates.

A great deal of educational work is done at the centre. Two films have already been made and a third is in the process of being prepared. Professional actors give their services free. Some ex-addicts work together with the professional staff.

Patients come voluntarily but are referred from other agencies.

The programme is based on—
Rehabilitation;
Prevention;
Treatment.

Emphasis is laid on the need for *caution in the use of methadone* as a form of treatment and the strict controls necessary. It is regarded of paramount importance that centres are not used by unscrupulous addicts to deal in illicit drug trafficking.

There is a day centre run by ex-addicts who act as a sort of therapeutic community where individual problems are discussed. I sat in at one of these group sessions at which Dr Chapple was present. No punches were pulled and everyone had their say if they had a point to make. Dr Chapple, however, stressed that they had to be on guard that the psychiatrist always held the upper hand, and was not manipulated.

Dr Chapple feels that the group must be welded together as a team. Educational weekends are arranged periodically at which patients are encouraged to express their feelings.

The Institute for the Study of Drug Dependence
Chandos House, 2 Queen Ann Street, London

This institute is located just off Harley Street. The institute itself is an independent body incorporated in 1968, as a non-profit making company, limited by guarantee and registered as a charity. It has the following principal functions:

1. To collect, collate, and disseminate information on all aspects of drug dependence.
2. To establish and maintain a reference library and information retrieval system.
3. To promote and undertake research into the causes, prevention, and the treatment of drug dependence.
4. To arrange lectures, discussions, and seminars, including international conferences.
5. To co-operate with other bodies, both national and international, in furthering study and exchanging information on drug dependence.
6. Generally to provide a centre for the study of drug dependence and to advance public understanding of the subject by all appropriate means.

It is stressed that the institute does not treat addicts nor does it give medical-legal advice. It is, however, able to provide information on the facilities and the resources that are available.

The library's collection of reprints and photocopies of journal articles continues to grow at an ever-increasing rate. Eight hundred items have been added in the last half of 1969 and a further 1,600 in the first half of 1970.

A recent analysis of 200 consecutive accessions show that they were drawn from 60 different journals, 51 medical and scientific, 9 lay, published in 19 countries and covering 13 specialist fields ranging from archaeology, behavioural biology, and biochemistry to paediatrics and psychiatry. A brief report on 800 consecutive accessions showed that no specialism contributed more than 12 percent of the articles.

New Horizon Youth Centre

This is a centre which provides a haven for the large number of young people adrift in the West End of London. They have no fixed abode and take up residence wherever they can find a spot under a bridge, a doorway or in a derelict house.

They have not chosen to be drifters but have found themselves at the end of the line following a chain of unfortunate experiences.

They are a group of young people who have either not been picked up by the welfare societies or who have slipped through the net.

To deal with this problem New Horizon was set up by Lord Longford in 1968. Two years later the centre moved from Soho to Covent Garden as a pilot scheme on which to build a more comprehensive service.

Structure

The administration of the centre is carried out by a council who look after the financial aspects, leaving workers free to get on with the practical side of the work.

Workers

At present there are three full time workers.

Facilities

The present premises consist of two basement rooms, toilet, and an office. The office is the hub of the set-up where private interviewing is done and confidential files are kept. The main basement room is used as a reception room and for activities. The second room is equipped specifically as a workshop and art room. Included in the toilet facilities is a small sanitary room in which registered addicts using the centre may inject themselves under the supervision of the workers.

Finance

Ultimate financial responsibility lies with the council. The centre is dependent predominantly for finance upon public subscription, and is a registered charity. Running expenses have totalled approximately £6,000 ($12,000) per year.

Work

The work falls into two categories:

1. *Immediate*—to deal with young people who either contact the centre by telephone or are referred by some organisation. Difficulties may range from accommodation to more deep-seated emotional problems. Some of them simply need help with their immediate problems and then they go on their way and are usually not seen at the clinic again.
2. *Long Term*—Here an attempt is made to provide long-term stability taking the form of involvement in one or another of the therapeutic activities in the centre and the establishment of meaningful relationships with the workers.

Visit to Phoenix House

This is a residential therapeutic community financed by a grant from the London Boroughs' Association. It is run by two Americans, and is based on New York's Phoenix House system. The Department of Health provides the building and the London boroughs help with maintenance by a grant. All work is done by Phoenix House staff. It costs £13 per week per resident.

This accommodation is the first of its kind to be set up in Britain and was started by Dr Griffith, a psychiatrist from the Addiction Research Unit.

It is assisted by people in the neighbourhood known as Friends of Phoenix and students from neighbouring high schools join in such activities as seminars and discussion groups.

In this centre there are two unassailable rules; no physical violence and no drugs, or intoxicants of any kind. They demand that an addict is "clean" (takes no drugs) for 7 days before admission. Nobody minds what his reasons are for joining but while he is there he must go along with the programme which is a fairly heavy regimen.

The residents are expected to attend seminars, and group discussions and learn something about themselves and other people.

As a final step residents join Phoenix pre-entry which is part of rehabilitation in a trade-training or profession or further education.

Drug Section, Home Office

Mr Jeffery, Chief Inspector on the enforcement side gave me a brief outline of the past events leading to the present system.

First controls leading to the present scheme started during the First World War when traffic in cocaine began in London and also a certain amount of opium traffic. Under the Defence of the Realm Act (D.O.R.A.) regulations were made to impose some form of control of cocaine and opium. In 1920 the first Dangerous Drugs Act was promulgated to implement the committee's requirements. It was decided that the Home Office should be responsible, and should act as a repository for information not handled by other agencies. It was also the licensing authority. Retail inspection of pharmacies was handed to the police in 1921. At the time the police force was completely autonomous. Initially, two inspectors were appointed by the Home Office but all regional medical officers of health appointed by the Ministry of Health were given powers under the Dangerous Drugs Act

only in respect of doctors records. Home Office built up an arrangement that police should report to Home Office if prolonged drug users were found, and this information was to be passed on to the medical officer of health who then visited the doctor concerned and obtained details. This situation pertained up till 1968.

The Rolleston Committee was set up in 1924 and asked to look at the question of whether doctors might make ethical drugs of addiction available to addicts. A report was issued in 1926 that there were certain conditions when doctors were entitled to do this. This led to the making of therapeutic addicts who were scattered through the country. The Home Office did its best to encourage doctors to play ball but this did not alter the figures a great deal. In 1951 an unqualified retired hospital dispenser broke in and stole heroin, morphine, and cocaine and began to peddle these in jazz clubs in Soho. Three months later, before police arrested him, all supplies were gone except for morphine. In increasing numbers customers began to approach doctors for further supplies of narcotics. Advantage was being taken of script doctors by pedlars. This situation continued through the 1950s at a slow rate. New regulations were promulgated in 1953. In 1955 the matter was again causing concern and in 1958 the Minister of Health decided that a committee should be set up to look at the Rolleston Committee report in the light of the new drugs on the market. This led to the Brain Committee of 1958.

In 1960 there was an explosion in heroin use (50 percent increase over previous years) and cases were coming up from the jazz musician areas. The increase continued each year. In 1964 it was obvious that something needed to be done. The Brain Committee reconsidered their report in 1965 and agreed that doctors had some responsibility and that they should notify the Home Office of addicts coming to their notice and that steps should be taken to restrict prescribing of narcotics in certain areas.

In 1968 powers were obtained for the setting up of special treatment centres and the restriction of prescribing of heroin and cocaine. Treatment centres were set up hurriedly by the Department of Health. However, the department could only advise hospitals to set up these centres as they were run by independent regional boards. A considerable amount of pressure was put on the department by the Home Office.

Almost immediately a certain practitioner started using intravenous amphetamine. It was agreed in 1968 to restrict supplies of methadrine to hospital pharmacies.

N.B.—In May 1968 the practitioner involved had issued 20–24,000 ampoules (800 a day on one occasion).

When some doctors started prescribing amphetamine sulphate powders which were being used by addicts the Pharmaceutical Society assisted by asking members not to dispense these scripts. The British Medical Association also advised their members not to prescribe and, by 1970, the problem seemed to have subsided largely by virtue of firm administrative action and professional co-operaton.

Another large prescriber of amphetamines had bouncers in his waiting room, and subsequently served a jail term.

Early in 1970 there were cases of primary and iatrogenic or doctor caused, methadone addiction. In the first 4 months of 1970 there were

111 cases of methadone addiction. It was, moreover, known that methadone was being sold by addicts under treatment to obtain Chinese Heroin.

Dr T. H. Bewley, Consultant Psychiatrist, Tooting Bec Hospital, London, S.W. 17

After the Home Office, Dr Bewley was one of the first persons I was fortunate to meet concerning drug dependence in general and treatment centres in particular. He is a member of the Council of the Institute for the Study of Drug Dependence, and has written many papers on narcotics and alcoholism.

The establishment of treatment centres must be soundly based, with careful control of those attending to ensure—

1. That there is no abuse of the drugs dispensed; and
2. That the centre is not conned into accepting a person as an addict merely because he claims to be one.

Even with what could be considered to be fairly rigid controls there are still many loopholes despite laboratory checks.

The staff in the clinic need to be related both in quality and number to the attendance figures of addicts to be dealt with, and good team work is essential.

The choice of therapy is one that comes within the field of the psychiatrist but it would seem that there is a need to get the patient off heroin as quickly as possible and on to at least methadone, preferably in elixir form. Prescriptions for these drugs are written on a special form, a copy of which is enclosed, and can only be collected each day except over the weekend where two days' supply is authorised. The patient must report next week for another prescription when he is seen by the psychiatrist. The aim, however, is to keep hospitalisation down to a minimum.

The possibility of an addict obtaining supplies from a number of clinics is obviated by the Central Register which is kept at the Home Office, to whom all cases must be notified.

I would like to mention that several persons have commented on the fact and stressed that there is no such thing as the "British system". In fact there has never been any such thing as a "British system". A series of administrative practices grew up at a time when there were very few addicts and those mostly in professions with easy access to opiates. This was described at a later date as the "British system".

Dr Bewley says "Acceptance of the maintenance method does not necessary mean acceptance for all time".

He outlines the following provisions:

1. It is essential that a uniform scheme of maintenance should be used in all maintenance centres and that the scheme is rigid enough to debar prescriptions to an addict because he has lost his drug, or sold it or given it away. If an addict comes with such a story and his wishes are met gross over-prescribing will continue. Such a person can be offered admission for treatment and supervision.
2. It is essential that careful records should be kept and that close liaison with the Home Office in relation to records, notification, etc., should take place.
3. Adequate procedures must be evolved to cope with the addict who has moved out of his area.

Who is fit to treat the addict?

This is a vital question. Dr Bewley feels that there are few persons, either doctors, nurses, or social workers—who have knowledge or experience in this rapidly developing field. Clearly to set up many out-patient services staffed by people who have little basic knowledge or little basic interest in the problem of addiction may well be disastrous.

The question of participation of voluntary bodies is also a very important one. Whilst it is considered that their place cannot be denied it is pointed out they need to be reasonably objective about the matter as the addict is often a past master at manipulating those who are emotionally involved.

Some Further Observations

We must be careful to avoid an emotional and hysterical approach to what could well be a major social problem in the field of social and preventive medicine. There are so many "cranks" on the drug band wagon that it is becoming increasingly difficult to make satisfactory progress in this field.

On the other hand, there are a lot of very genuine people both in the professional and lay field who could be given an opportunity and indeed even some financial assistance provided they are willing to work with and not against the established policy of Government. It was stressed to me strongly enough that whatever is done in New Zealand must be done *quietly, rationally, and with the minimum of publicity.*

On my return to this country I felt what is undoubtedly a problem, but a relatively small one in New Zealand, has been blown up out of all reasonable proportion in the media and in various other ways. This, in my view, has stimulated the almost pathological interest of too many impressionable young persons.

October 1971.

(c) Dr A. H. Paul, Deputy Director, Division of Clinical Services, Department of Health

Observations on the Use of Methadone in the Treatment of Drug Dependency

In the course of a World Health Fellowship, in the first half of 1973, to study the control of pharmaceutical drugs I was able to devote some time to drug abuse. I visited six clinics for drug dependants and talked to psychiatrists and regulatory authorities in eight countries; the observations which follow are based on these visits and discussions.

Methadone and the General Practitioners

The use of methadone in the treatment of drug dependency is not satisfactory in the hands of the private physician.

Almost without exception, where this is permissible some physicians prescribe the drug too freely, whether for financial gain, from ignorance or due to carelessness. Instances were quoted of doctors prescribing methadone concurrently with dilaudid, a death from methadone overdose resulting from the doctor leaving a prescription for 4 days' supply

of methadone tablets on the verandah of the patient's home and an instance of a doctor leaving his surgery open with prescriptions on his desk for patients to come and pick up.

In general the private physician has not the facilities at his disposal to assess the patient adequately nor to monitor his progress. Access to a laboratory for urine testing and to ancillary staff such as counsellors and social workers is usually lacking, as is the ability to ensure that the patient actually takes the drugs prescribed for him as directed. Inevitably a proportion reaches the illicit market.

Methadone in the Clinic Setting

Methadone is widely used in the drug clinic setting but the results obtained in achieving a drug-free state are universally disappointing. Short-term withdrawal from heroin dependence utilising decreasing doses of methadone has a very high reversion rate. So high that short-term withdrawal is no longer attempted in some clinics, or no withdrawal is attempted at all unless the patient requests it. Figures from one clinic after a 3-year survey were 45 percent maintained on methadone, 44 percent either reverted to heroin, dead, in jail or untraceable, and only 11 percent thought to be drug free.

There was, however, an impression held in most clinics using methadone that their patients were better citizens maintained on methadone than left to obtain drugs on the illicit market. The incidence of crime related to maintaining an illicit supply was considered to be reduced and a sizeable proportion of patients were able to obtain and continue in employment.

All the clinics visited had psychiatrists either on the staff or accessible and facilities for testing urine and for daily administration of methadone. Staff usually included secretarial, nursing, counselling, and in some cases rehabilitation personnel.

Methadone in Institutional Treatment

In Hong Kong a voluntary organisation and a government organisation each run an institution for drug dependents. The former uses methadone for withdrawal over 14 days after admission, the latter for withdrawal in selected cases over a short period of 3 to 4 days, usually in conjunction with other drugs.

Both institutions follow the withdrawal period with a prolonged period of psychotherapy and rehabilitation, utilising case workers. The problem here is different in many respects from that found in western countries but the overall results, although still disappointing, show an eventual incidence of drug free patients of from two to three times greater than was found elsewhere.

Psychiatric Opinions on the Use of Methadone

As would be expected, the opinions of psychiatrists on the place of methadone in the treatment of drug dependence, varied widely. Those working in the clinics, naturally, were in favour of the methods employed there. Some considered there was no place at all for this drug and one would not accept patients unless they were prepared to withdraw from drugs completely first. Then after careful selection, patients were accepted for treatment over a prolonged period in a psychiatric hospital mixed with other patients.

The consensus of opinion was, however, that methadone has a place in the treatment of drug dependence, but that it is certainly not a solution to the problem.

9 August 1973.

2. PERSONAL COMMUNICATIONS

(a) Dr J. R. E. Dobson, Department of Psychological Medicine, Christchurch Hospital

Prevalence

Patients coming under care of this department between 1 January and 31 December 1971—

Opiate users	23
Lysergide, Amphetamine users	5
Ages 16 to 25 (two patients aged 30 plus years).	
Of opiate users: 2 not considered physically dependent; 19 considered physically dependent;	
11 patients referred before 1 September 1971;	
17 referred after 1 September 1971.	
Total	28

General practitioners in conversation mentioned several other apparently similar cases seeking opiates for control of abstinence illness, but declining offers of referral.

Treatment Philosophy

This department offers:

(a) Brief inpatient care to achieve drug withdrawal—if necessary repeatedly. The basic requirements of successful treatment is the establishment of a working relationship with the patient. This is unlikely unless withdrawal is made readily available. It is very easy to keep one's unit free of those difficult demanding and provocative patients. Provision of a setting which encourages them to seek treatment requires care and skill.

(b) Day care—outpatient treatment: Aimed at problem solving without drug use leading to tax paying status. In general we agree with the WHO Working Group, 1971, that as this group of drug abusers invariably have multiple personal and social problems which precede drug use, they should logically be treated within the framework of the general social, medical, and psychiatric services.

Misuse of drugs —especially opiate dependence—seriously complicates pre-existing disability due to maladaptive personality functioning. For many years we had treated with variable success large numbers of patients, with no record of drug dependence, whose adverse developmental experiences, patterns of educational, vocational, and social failure have been identical with those found among drug users. These patients usually referred after admission to hospital following suicidal behaviour, comprise about one-half of attendances at our day care programme during recent years. Though studies affirm the benefit of

psychiatric treatment for such patients, resources in New Zealand for this group are markedly inadequate and many psychiatrists decline responsibility for them.

Earlier Intervention

Likewise—in spite of evidence of failure being manifest early in secondary school—facilities are sadly lacking for definitive assistance at this early phase when intervention is most likely to be effective. The difficulties experienced by the Child Welfare Division in coping with urgent tasks so that they cannot undertake effective preventive work exemplifies their problem.

Special facilities

The method and style of treatment of drug users does not differ significantly from that provided in any modern treatment programme for patients with impairment of personality functioning who are not promptly relieved by specific medication or E.C.T. Thus a proportion of drug-using patients can be absorbed into a general psychiatric treatment programme, where they will find a number of young patients with problems and disabilities similar to themselves, but for whom drug use is not important.

The demands for special facilities arise from the marked tendency of drug users to solve their identity problems by forming a close knit subcultural group where drug misuse becomes an important identifying factor and preoccupation with drugs and their effects a dominating activity. The strength of this group identity may be enhanced by community attitudes, legal sanctions, and adoption by the group of values which differ from the middle aged, middle-class citizens who control treatment facilities—both medical and social.

Thus most specialised units describe their major task as that of assisting medical and nursing staff to adapt to their initial reaction of hostility to passively unco-operative, anergic young hedonists—who "could help themselves if only they tried". This acceptance, regarded as essential by WHO Expert Committee, 1967, is surprisingly difficult to achieve, even among reasonably sophisticated and experienced nursing and social work staff.

Patients who have not become too firmly identified with the deviant drug using subculture can be treated successfully in a general psychiatric setting, perhaps attending a closed small group for drug users. Users who have developed firm identification are likely to require separate facilities with considerable responsibility for control and organisation of rehabilitation in the hands of ex-users who may have staff status.

Alcoholics Anonymous provides a useful and fully established model; thus some patients will require life-long support in the socially useful role of a non-using ex-drug user.

Compulsory Residential Treatment

This is a topic which produces heat and many ill-founded statements. Its value has once more been called in question. Until the indications and methods of this form of management are clearer, priority should be given to provision of adequate facilities for voluntary treatment (WHO, 1967).

Finally we commend to your committee consideration of the views of Sir Denis Hill (p. 117, *Psychiatry in Medicine,* Rock Carling Fellowship. Monograph, 1969.)

18 January 1972.

(b) Dr Edwin T. Hall, Medical Superintendent, Sunnyside Hospital, Christchurch

I am reluctant to express very firm opinions about such matters as my personal experience of treatment of such individuals is rather limited, with the exception of treatment of alcoholics. In Christchurch, up to date, those patients with drug dependency and abuse have been small enough in numbers to be treated by individual psychiatrists; at the same time it is thought that in the not too distant future some special group or unit will be required for such patients. There is an alcoholic unit at Sunnyside Hospital, which is at present functioning very well. Up to the present time we have considered that individuals with drug addiction or dependency would be inappropriately treated in such an alcoholic unit, but I do know that some people would have a contrary opinion, and mine could change within the next 12 months. I think this illustrates my difficulty in answering your letter. However, no doubt you require to have this sort of information as well as the very definite and positive views of some individuals.

I would certainly conclude with the comment that in our present state of ignorance we should not try and develop any national standard of treatment but attempt small pilot schemes appropriate to the personnel in various main centres.

1 November 1971.

(c) Professor Basil James, Professor of Psychological Medicine, Medical School, University of Otago

Concept of "Treatment"

The results of "treatment" of drug dependence are not encouraging, and it must be recognised that medicine has been conspicuously unsuccessful in its approach to the problem. Sadly, this lack of success—if by success is meant ability to "cure"—is not confined to drug dependence. Pemberton's article in the 1971 *Lancet* is a much neglected classic. In patients discharged from an acute medical ward followed up 1 year later, over 75 percent still had their symptoms; and of the other 25 percent not all were cured—some were dead. Pemberton's comment was that this apparent failure was due to the neglect of social and psychological aspects of disease.

It has seemed to me for a long time that the conventional medical model of disease is unsatisfying. I now prefer the word "understanding" to that of "diagnosis" and that of "management" to that of "treatment". Management of any disorder should be seen as occurring at two levels. First, the acute level, when the illness is in some critical phase, such as an acute asthmatic attack, diabetic coma, etc.; and the longer term management of the chronic phase. This way of looking at things is particularly applicable to the problem of drug dependency. I shall

not be touching on the acute management of the crisis phase of withdrawal, hallucinosis, etc., as I am sure that you will have many excellent submissions on this aspect. I would like to draw your attention particularly to the preventive and more long-term aspects of management.

General

Much more emphasis should be placed upon the understanding and management of the person, and less preoccupation with the drug. You may have heard my analogy of an epidemic in which people hurl themselves under buses. This is not dealt with by removing public transport; a serious attempt is made to understand what it is that motivates people in this way.

Aetiology/Preventive

There are of course very many determinants in the aetiology, and actual drug dependence can be seen as the final common pathway. It is now documented beyond all doubt (and your own first drug report adds to the weight of documented evidence) that the person who becomes drug dependent is a deprived person—deprived socially and deprived emotionally. Although on the whole of above average intelligence, he has much less education than the average. Nearly half come from homes in which the parents undergo physical separation through death, legal separation, or divorce. About 20 percent have fathers with a drink problem. About 40 percent have evidence of neurotic disturbance in childhood, and a considerable proportion show evidence of psychological and social dysfunction by court appearances unrelated to drug taking before they present to medical agencies. These criteria which I list are the most obvious aspects, available to the most naive inquiry. I have no doubt that more careful psychiatric investigation of family dynamics would reveal a very very high percent indeed of severe family dysfunction.

Essentially, drug dependence is a *symptom* or a complication and not a disease or a cause of a disease. It has been shown that the vast majority have a severe depressive core to their personality, though deny feelings of distress and illness in a way which has been described as hypomanic. As someone has put it—"I may have a smile on my face but I hurt inside". Although only 22 persent seem to express shame or remorse about drug taking, nearly twice that number attempt suicide, many of course die, and getting on to narcotics probably has the same uncaring, self-destructive component as my analogy of jumping under a bus.

In the management (or "treatment") of disease one must make sure that the treatment is better than the illness. To quote Florence Nightingale—"It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm". I am in no doubt that our psychiatric institutions are so woefully understaffed and so misapprehend the problem that this "very first requirement" is in some doubt. If the Drug Committee has not seen the "Man Alive" film *Gale is Dead* may I make a plea that they do so. It is available from the National Film Library, and shows the origins through illegitimacy and unwantedness, through institutions and despair, through the futile application of the medical model of "treatment" to severe drug dependence and finally death at the age of 21. This is a record of failure to comprehend the essential nature of drug dependence, and what lies beneath it.

Drug dependence can be seen as one expression of distress in a person whose personality has become crippled. If one removed drugs, this would not alleviate the suffering. It would be expressed still in delinquency and crime (though doctors could with a clearer conscience wash their hands of that!), frank psychiatric disorder, and suicide in one form or another.

My plea is for the *person* to be taken seriously; for his suffering to be understood; for the psychological and social determinants to be comprehended; for the family to be the major unit of study; for a massive programme of research; for an even more massive programme of public education—and medical education—for even though our knowledge is limited, sufficient is known for us to take active steps which are meaningful and not just conscience-salving. My plea is to see what is under our noses, to do something about it, and to abandon any notions of drug dependence which label it as a "disease" with a single aetiology, and which overemphasises the physical and pharmacological aspects. These are of course important, but what is needed is a large number of professionals who can educate and prevent, and who can provide in the person-to-person sense the essential ingredient for the alleviation of this personal tragedy.

"The way out is via the door. Why is it that no one will use this method?."—Confucious

15 May 1972.

(d) Dr Fraser McDonald, Medical Superintendent, Kingseat Hospital

Herewith, a few of my comments on the treatment of patients suffering from drug dependency.

Basically I feel that the present mental health/mental hospital setups are just not suitable for treatment of these people, especially the very young or the adolescents. These people fall into two major groups both of which fit in very poorly into our present addiction programmes which are mainly concerned with alcoholism and with barbiturate addiction in middle-aged women. The two groups are (a) those who are violently opposed to any sort of direction from authority and are "rebels without a cause". They are basically impulsive, self-directed usually with a rather vague philosophy on personal freedom which fits in very poorly with the rather dull self-discipline sort of approach of alcoholics anonymous which is the basic therapeutic orientation for any addiction programmes certainly at Kingseat Hospital; (b) the second type are the borderline psychotics, the aimless, motiveless, non-goal directed drifting borderline schizophrenics. These people also fit in very poorly into alcoholism treatment programmes as they definitely do not participate in the sort of group therapy current in alcoholism treatment programmes which is usually heavily dependent on quite a lot of verbal interaction among the alcoholics and these people tend to get very lost. They find themselves quite unable to identify with any of the successfully treated alcoholics and addicts who frequently attend these groups who rather tend to be quietly extroverted dedicated to the goals of lower middle-class non-drinking New Zealand society, these goals of course being totally unrealistic for these people. . . .

The overwhelming impression I have of the various types of treatment that I have tried with these patients is that without any doubt whatever, methadone replacement therapy is quite essential in whatever treatment programme is envisaged for these people. This can be short term by which I mean 3 to 6 months, or long term by which I mean for the foreseeable future for these people, in the sense of giving a schizophrenic Stelazine for the rest of his life. The reason for this is that I think that these people are so disturbed emotionally and physically by the time they get the treatment that they require at least 3 months maintenance on a good solid dose of methadone in order to let them collect their wits and start thinking seriously about what they are going to do with their lives. It takes a least this length of time for them to establish trust with their therapists, it takes at least this time for them to be able to build up physically so that they are in a position to start deciding whether they want to give up drugs or not.

In short, I feel that treatment procedures in the past have been oriented too much to what we as administrators and doctors think is good for the addicts or is what the addicts *should* have as far as treatment is concerned. I am afraid it is absolutely essential that we accept the realities of life and tailor our programme so that it fits in with what the addicts *want* from treatment and are prepared to accept from treatment and that we should then graft on to this, those aspects of treatment which we feel the addicts need rather than the other way round. This applies to treatment and follow up procedures and committal procedures.

10 January 1972.

(e) Dr M. G. Mackay, Medical Superintendent, Porirua Hospital

I have to state that without an extensive search through our records it is not possible to give an exact report on the number of persons who have been here because of drug abuse or dependency or on their motivation, mental state, etc. In discussion with medical staff and social workers the following comments arose and may be of assistance:

1. LSD appears to us to be a very dangerous substance which has the effect of producing prolonged mental disorder in unstable persons.
2. We have found little in the way of withdrawal affects from any drugs.
3. We do not believe that persons need to be maintained on narcotic or other addictive drugs and that drug therapy if needed can be carried out with the usual tranquillisers, antidepressant drugs, etc.
4. Individuals who become dependent on drugs are, in our opinion, pathological individuals—in other words we do not see normal persons who become attracted to drug taking through wrong associates, etc.
5. The persons we have seen have covered the full I.Q. range from mentally dull to above average.
6. Persons we have seen come from all social levels.
7. In almost all cases we have great difficulty in following up these persons and in maintaining contact with them.

28 October 1971.

(f) Dr S. W. P. Mirams, Director, Division of Mental Health, Department of Health

In response to your request I set out below some notes on the treatment of drug abusers. In preparing these I have consulted extensively with Mr T. H. J. Austin, Advisory Social Worker to the department, and Dr A. G. Frazer whose present clinical work in child psychiatry brings him into close contact with a number of the adolescent group of drug users. I think all of us who have been concerned in preparing these notes would wish it to be clearly understood that in our view the present state of knowledge does not justify dogmatic statements with regard to the treatment of drug abusers and for this reason we would see the following comments as offering nothing more than guidelines for the immediate future.

Treatment of Drug Dependent Persons

A. General Considerations

Although members of the Board of Health Committee will be well aware of these already, it is desirable to reiterate certain propositions which, in the present state of knowledge, should be seen as the background against which the detailed planning of treatment facilities and programme should proceed.

1. There is a trend, even in some professional literature, to use the term "drug abuse" as if it is equivalent to or actually the name of a specific disease entity. There is a corresponding tendency, particularly among concerned lay persons reading such material, to assume that a cure will be found; or what is worse, that a cure is already known and has only to be applied.

2. As in other medico-social problems defining and planning the inter-relationship of specific therapy, social factors, restraints, and sanctions in any broad treatment programme is a demanding and complex task. It may well call for a greater degree of flexibility in both individuals and institutions (including legal and penal systems) than is readily forthcoming. For success, there needs to be a willingness to examine critically present methods, their effects and consequences.

3. Although many, probably the great majority, of drug-dependent persons have major personality problems and a proportion are suffering from identifiable psychiatric illness, the problem is not to be seen as one exclusively for the psychiatrist. This comment applies even to the more narrowly identifiable "medical" aspects of the problem. As in the field of alcoholism, it is more important to have a physician who is knowledgeable and professionally interested in the challenge that it offers, than to have somebody drawn from one particular specialty, as the medical member of any treatment team. The point should be made, however, that no treatment team can be fully effective without readily available psychiatric consultation.

4. A high proportion of people who become drug dependent have, or develop, a marked skill in manipulating others. Anyone, whether lay or professional worker, who is unable to accept this as a simple "fact of life" is unlikely to be an effective member in a treatment team. (In passing it may be observed that any body who is convinced that he is either too shrewd or too competent to be manipulated is not an appropriate member of a treatment team.)

5. Some sanctions are necessary as part of the total provision in any comprehensive programme. These should not be a prominent feature of the programme; but since the general topic of sanctions is itself a controversial one, quite independently of the "drug issue", it is almost impossible to have this point discussed in an objective way.

6. It must be acknowledged that some professional and other workers believe that the use of sanctions is altogether inappropriate; or at least feel that they themselves cannot work effectively in any setting where sanctions are an accepted feature of the regime. It must also be acknowledged that, because of the uncertainty of present clinical information, there is a need to ensure that such sanctions as are available are not operated in an arbitrary and inflexible way. It is particularly desirable to ensure that they do not make it easy to apply routine treatment regimes uncritically to groups of people whose only common feature is that they have been misusing drugs and are now under sanction.

7. It is platitudinous to observe that the problem of drug dependency is complex and not capable of quick or easy solution. Perhaps for that very reason it needs to be emphasised that in the present state of knowledge the greatest chance of success appears to lie with an efficiently lead multi-disciplinary professional team. The contribution to be made by lay people in the treatment may be considerable, however at this stage it needs to be carefully explored.

B. Treatment of the Heavily Involved Younger Age Group

It is to be assumed that some of the characteristics of this group will include resentment and frank hostility to authority, including the valuing of social nonconformity for its own sake. Some members at least will be restless in an intellectual sense while, at the same time, intellectually demanding. It is also to be expected that a proportion of those who emerge by group process as recognised and acknowledged leaders, will show a significant degree of psychiatric abnormality. Against this background certain principles can be set out for the planning of a service; at least as it would be in the ideal setting.

1. *Organisation*—(i) There are advantages in having a separately established foundation or organisation identified directly and probably exclusively with this work. At the same time it is essential that any such scheme have adequate and efficiently working links with established health, social and law enforcement agencies.

(ii) It is desirable for the organisation to operate from a setting which is clearly seen to be neutral and which is not physically linked with the conventional forms of service already referred to.

(iii) It is not essential that the service be medically directed. A suitably qualified and experienced clinical psychologist or social worker would be more effective than a doctor without the appropriate qualifications.

(iv) Any project which is undertaken should be so planned that evaluation is possible at regular and planned intervals.

2. *Staff*—(i) Key staff in the organisation must have appropriate professional backgrounds and preferably specific training, as well as interest, in drug dependency and its treatment. (It is acknowledged that in the initial stages this ideal may be particularly hard to achieve).

(ii) Staff appointments in any treatment programme should ensure some diversity in individual personalities and backgrounds, as well as in professional training. Medical and psychiatric consultants must be readily available to the service, preferably on a "crisis intervention" basis.

(iii) Staff establishments must take full account of the demanding nature of the work both in terms of the emotional and physical stresses that are involved. In particular the necessity for 24-hour coverage at times and crisis calls at all hours must be taken into account. If a pilot project is to be established it would be better not to begin until reasonable staff resources can be assured.

(iv) In planning for staff, full account should also be taken of the possibility of useful involvement of carefully selected salaried lay people and voluntary workers. Where this is done it must be required that some acceptable preliminary training, and further in-service training, is provided for all lay workers.

C. Facilities for Other Drug Abusers

1. Probably effective treatment can be provided for well-motivated older drug abusers on a less elaborately organised basis. The general considerations set out in the previous section will also have relevance, but the conventional medical and psychiatric resources can more readily and appropriately cope with this demand. It is desirable that the work should, whenever practicable, be channelled to professional people with special experience and training. In centres where specially designated drug treatment services exist, these workers should have recognised links with such services.

2. For the poorly motivated or recalcitrant older drug user sanctions may be required. These are likely to be operative within the framework of mental health and penal services. While there is an obvious need to strengthen therapeutic resources in these services, it is doubtful if there is any urgent need for any great expansion, except for the treatment of Alcoholism.

D. Conclusion

Any proposal to establish a service taking account of the suggestions made in the preceding paragraphs would require a considerable allocation of professional staff. In the present situation in New Zealand most, if not all, of these would have to be drawn from areas in which there are already significant shortages. There might well be resistance in some quarters to the allocation of scarce resources in this way. While these views should not be allowed to prevail in an area where there is an obvious need for more therapeutic endeavour, the great risk is the involvement of too many enthusiastic "amateurs" from both professional and lay fields in an attempt to find some solution. Despite the very great pressures which there may be for the development of services it is essential that considerations of competence and suitability of the staff provided should at all times be the primary consideration.

23 November 1971.

(G) Dr P. P. E. Savage, Medical Superintendent, Oakley Hospital

Medical Treatment and Total Care of Drug Misuse and Dependency

Treatment in any area where success rates are low invariably generates a multiplicity of "cures" and strong advocates of single and exclusive approaches. It also generates much emotionally tinged discussion by sincerely inspired proponents with a narrow view. Nowhere is this better borne out than in the field of drug misuse.

It is convenient at this juncture to refer to the statements in the first report of this committee, in particular to those in paragraphs 9.1 and 9.2 on page 52.

These read:

"9.1 Besides those convicted of drug offences in the courts, there are other people involved in both drug dependency and drug abuse for whom treatment must also be provided. However, identified, drug dependants and abusers vary in many different ways: in the drugs they use, the dosage and manner of administration, and their physical reactions; in the degree of their personal and social involvement with drug taking and drug takers; in their attitudes to their own use of drugs, and to treatment and cure; in their motivation to stop or carry on; and in their relationship with the medical profession on the one hand and the police and the law on the other. Treatment must begin where the patients are: it must be designed to meet their varying needs and circumstances. Assessment is therefore an essential preliminary to treatment—or may perhaps best be regarded as the first step in treatment. To deal with a group as varied as this, not one or two but a range of different kinds of facilities are required both for assessment and treatment.

"9.2 *Aims of treatment.* In general, it is agreed among workers in the field of drug dependency and abuse that treatment should aim at securing the elimination of dependence and the cessation of abuse in patients treated. However, from time to time the argument is advanced that, under certain circumstances, persons in an advanced stage of dependency who have not responded to efforts to get them to cease using drugs should be officially permitted to be maintained on their drug of dependence by an authorised doctor."

Comprehension of "treatment" in the field of drug abuse hinges upon the understanding that some involvements necessitate medical treatment and some do not. (Drug involvement being defined as the interaction between a person, a drug, and society.) Again some who require medical treatment may require active medical treatment for short periods only though they could need medical oversight for long periods, to note the signs of renewed dependence, and supervision of physical and psychological complications of the effects of drug taking, or even for some psychiatric condition which precipitated or predisposed the drug taking.

"Total care" means that disciplines other than medicine and nursing must be invoked in the care of drug involved persons, whether actively taking drugs or subsequent to an active phase. There is usually a time sequence; firstly, medical and nursing involvement followed by involvement with a social worker who may later devolve some quantum of management and rehabilitation to a relative,

employer, or friend, or to a volunteer social worker with little special training, but much good will.

Should relapse occur there may have to be a reverse sequence of those involved until the tide turns again towards advance in a socially suitable direction.

The very lightly involved may not need medical care at all but may benefit from social work care and supervision.

In the field of assessment much may be contributed by a psychologist who can also participate in suitable treatment situations such as group therapy, or counselling.

Somebody, obviously, must have some overview and decision making power, when this galaxy of helpers is reviewed. At present the one person commonly familiar with medicine, psychology, and social problems, used to working with colleagues from the fields mentioned, and with decision and responsibility in both medical and sociological settings is the psychiatrist. It is thus not difficult to see how drug misuse has almost invariably been attached to psychiatric programmes all over the world; the psychiatrist being ordinarily used to adding the skills of psychologists, nurses, social workers, and occupational therapists to his own in facing psychiatric problems.

In the field of preventive medicine, the therapist, or programme organiser, has frequently to face sometimes illogical resistance to treatment or assistance, and has also to take cognisance of and responsibility for the likely effect of the affected person's condition and behaviour upon the uninvolved members of the community.

The evolution of clinical progress in drug misuse cases often bears a reasonable resemblance to the model of chronic medical illness in general medicine and psychiatry. The march of acute illness, remission, exacerbation, remission—spontaneous or induced—and the phenomenon of residual disability of varying levels, with its ofen temporary regression, are only too familiar in social and preventive medicine, a picture often being compounded by human attitudes, helpful or otherwise.

Who are the drug misusers and how do they differ from those uninvolved with drugs? Drug misusers who come most frequently to public notice seem, in New Zealand, to come overwhelmingly from youth. First drug use is commonly at about age 15 with a measure of involvement about 3 years later which seems to attract public attention to the degree of police or family invocation of compulsory care.

What separates the drug abuser from the rest of the youth group at risk? From presently available research in New Zealand and comparable countries it appears, at least, to be the possession of what psychiatrists define as a passive psychopathic personality. The traits which make up this syndrome are irresponsibility, impulsiveness, passivity, the inability to form lasting relationships, a failure to profit from experience as well as general immaturity with a low frustration tolerance, sometimes even a certain callousness. Intelligence is well within the normal range and, indeed may be above the mean.

This catalogue of what some would regard as non-virtues, helps to explain the social histories and life style of many drug misusers and the often regrettably mixed impression they create on those who become involved in their lives, whether this be in either an active or passive manner. There is a high incidence of a history of broken homes.

First consider the group at risk. The young person moving from childhood to adult life faces a bewildering array of choices, some generally approved, some not, but most attractive at some stage.

The selections made will be determined partly by the effects of earlier experiences, by the advice they will receive from adults and, partly, by their ability to defer immediate gratification and accept longer term rewards. This latter is also determined largely by their earlier experience.

The adolescent may opt to leave school early and, as a group, drug abusers do so having already left behind them a record of underachievement for a relatively good intelligence—generally above average. The short-term result of this is often entry to an occupation financially adequate, but otherwise unrewarding, since the majority of users are found in unskilled occupations well below their intellectual capacity; the result—dissatisfaction and longings for some other satisfaction.

At this stage in life the young person, often somewhat apprehensive, has all manner of pressures placed upon him by his parents as part of their contribution to his learning about life. Faced with these pressures and the need to explore life it is not difficult to see how easily unwise experimentation with drugs may become part of the pattern, especially in the vulnerable personality.

Logically "treatment" by education would seem the answer at this juncture. Regrettably, something in the potential misuser's personality or environment makes him resistant to much in formal teaching—peer pressure not to believe being a counter influence.

The personality at risk, through introduction to a drug, may well become an experimenter. Should he continue, the road to misuse takes an easier gradient.

It might well be asked at this point how the use of a drug which is medically beneficial in some circumstances, can be regarded as evidence of disorder or "disease" in other situations. The following three points will assist in understanding this apparent paradox:

1. Those drugs commonly capable of misuse are, in the therapeutic situation, controlled by a person other than the recipient.
2. These drugs cabable of being misused usually elicit the phenomenon of tolerance, that being the need for gradual increase in dose to produce the same effect as the body becomes used to the drug. The sought-after effect in youthful drug abuse is generally not relief from physical pain but is psychological and includes dispelling boredom or a positive search for some euphoric experience.
3. Most drugs susceptible of abuse change the body chemistry subtly to produce a state that, when withdrawn suddenly, after the dependence referred to above is established, many normal psychological mechanisms become painfully "dislocated" producing the "withdrawal syndrome". Complete avoidance of withdrawal symptoms naturally means a perpetuation of the "adequate" dose, that is dependence.

Though the criterion of 1 would apply to almost all present legally defined narcotics, the situation described in 2 and 3 is confined, in varying degrees, to drugs that are pharmacological narcotics and also to the amphetamine group.

With the indication of a true physical dependence, with the inevitability of some withdrawal phenomena, active medical supervision, preferably in hospital, is advisable for comfort, safety, and continuity of treatment.

Indeed, withdrawing drug-dependent patients may well seek such treatment in a hospital setting of their own volition, spurred on by the acute discomfort of withdrawal.

It is difficult to make the process of withdrawal entirely comfortable, however well covered by other medication. The patient is thus faced with a choice of mustering the vitality needed to accept the situation voluntarily over a period of up to 3 or 4 weeks, of seeking the relief of symptoms by discontinuing treatment, or of obtaining more of the drug of his choice for self-administration. By virtue of ready contact he may seek this latter course either through illicit channels or by way of prescribing by a medical practitioner having a reputation in user circles of not asking the sort of questions that a prudent practitioner might ask of a person requesting a narcotic prescription.

Thus the dependent and society are faced with the choice either to permit the addiction to go on forever increasing its demands on the individual, by increasing dosage and decreasing social usefulness, and on society, by paying for this state and its treatment and such concomitants as hepatitis or to provide some mandatory care, albeit against the individual's will.

Society has never shrunk from mandatory treatment for serious contagious diseases. Neither has it shirked responsibility when an individual's behaviour imposes dangers on himself or others, and is maintained by his belief that he need not alter it. This latter situation is well covered by committal clauses of the Mental Health Acts of virtually every civilised country. In many countries, including New Zealand, special Acts cover the processes of securing compulsory treatment of states of addiction and abuse of alcohol and drugs. Such acts are designed to protect the abuser from himself as well as all groups in society especially the groups most at risk. However, like the horse, the water, and the drink, the eventual co-operation of the patient is usually necessary for any real hope of success. Unfortunately, the good of the patient and the safety of others is sometimes less highly regarded than are the legal niceties in committal procedures.

It is not difficult to administer fairly effective inpatient medical and nursing care in a suitable section of a hospital. The immediate post-discharge period is notoriously a period of relapse. Extramural nursing and social work follow-up should commence early but workers can tell of many difficulties encountered in trying to contact, let alone support and treat their patients. Only too familiar to these workers are the long trips to an address only to find the patient has moved off in the usual nomadic manner; let alone the broken appointment, the slipping away from the assessment session as soon as a supervising back has turned, and the rejection of advice and work opportunities. However, such efforts must continue. Though many patients do not co-operate, some do and are even grateful for the support, and benefit thereby.

Occasional unscheduled urine screens for drugs are essential to detect a rapid return to drugs, or to detect non-prescribed drugs in those who are taking a maintenance narcotic. The knowledge of the likelihood of such checks undoubtedly has an inhibitory effect upon the temptations of some patients, especially just prior to a suspected check date.

One of the major difficulties faced by the rehabilitation worker is the establishment of the work habit. This habit may have vanished during some months or years of dependence, when even a previously regular worker may have drifted into a casual work role designed only to procure drugs and subsistence living; again there may never have been any work habit in the case of the youth who became addicted at school and drifted from short-term unskilled job to job to finance drugs and life in a sleazy "commune".

To different readers of this report the word "commune", generally "youth commune", may have different meanings. However, to the social worker the word generally infers a collection of persons of assorted sexes living together in an old house in a highly shared existence. The members are all expected to contribute to the expenses in regard to food and may even take it in turns to work for short periods for the common good. Property and clothing are likely to be shared and, for periods, a member's disinclination to work and not to contribute may be quite acceptable. Living standards tend to be at the subsistence level and conventional community standards may or may not be observed. Considerable affection and kindness may be reciprocated by members but regrettably the life is hardly a preparation for survival, let alone success, in the average society of this day and age.

The commune life allows the ex-user to settle into a subculture which does not encourage links with the wider community and in the long term, unfortunately, reinforces under-achievement through rejection of conventional goals. The ex-user is likely to meet only ex-users and persons who may belittle any progress, with predictable results.

Assuming that the patient has managed some recognisable degree of community involvement and work pattern, the supporting social worker must still cope with the low frustration and discomfort tolerance of the ex-user in the face of inevitable stresses. The ex-user is doubly vulnerable as, in addition to his personality failings, he possesses the knowledge that a sure short-term relief in the shape of drug use is only too easy to find again.

It comes as no surprise to learn that some ex-users cannot refrain from relapse. Thus it comes about that some workers have tried saturating the patient with what is considered a more manageable opiate in order to deter the patient from taking other more destructive narcotics such as heroin. Time is telling against the over-optimism of such workers in this field.

Narcotic maintenance, a short-term measure, and blockade unfortunately can, and indeed do, create problems unless carefully handled within a suitable framework of controls which limit the sources of the drug to a few designated facilities able to dispense daily doses, which must be consumed on the premises to prevent perversion of its use.

The synthetic opiate methadone (Amidone HC1) is often used for this purpose of maintenance and, if saturation is aimed at, the method is known as methadone blockade. Such medication is claimed to reduce the pleasurable effect of other narcotics to a level where the user may well consider the difficulties of their illegal procurement to be not worth their now dulled effect.

This worthy aim is unfortunately not easy to achieve, as quite a high dosage is often necessary and, while the dosage level may make

the subject relatively immune to temptation, it may reduce the inclination to work. However, some patients do better and work effectively. The long-term goal of this treatment is the creation of a normal life and work pattern followed by gradual withdrawal to a drug-free life when the patient and therapist are better able to handle this crisis. However, this long-term goal may take a year or two to achieve and can sometimes be actively resisted by the patient whilst the phenomenon of drug tolerance cannot be altered so long as the medication persists.

There is general agreement that the opiate prescribed must be consumed in the presence of persons who can ensure that it is not perverted to some other use. Overseas experience has clearly demonstrated that narcotic maintenance and blockade clinics, generally using methadone, have to rely upon daily doses to the user who must attend the facility. Many users, of course, complain of the inconvenience, but this is one of the inescapable penalties and also one of the features which may well motivate towards ultimate withdrawal.

Unfortunately, this daily dosage system does of course use many man hours each week. There is some hope in the overseas reports of experimental work using analogues of methadone, for example, methadyl acetate, these new drugs having the reputation of a narcotic blockading effect for from 48 to 72 hours. This represents a gain in time and economic use of personnel in drug clinics as well as increasing convenience to the patient.

At the time of writing, such drugs have not passed the research stage overseas and are not available in New Zealand. Their proponents again stress the importance of their restriction to consumption before a user leaves the treatment clinic to prevent even greater dangers to the patient due to their long action.

Prescription of narcotics and dispensing to the patient clearly has its dangers. The low resistance to temptation and the need for gratification may tempt the patient to misuse the prescribed drugs in a manner other than that the prescriber instructed. Oral tablets, which would reasonably manage the case requirements if used in the terms of the prescriber's instructions, have been ground up and injected intravenously with the deposition of foreign material, generally talc from the solids of the tablet, in blood vessels, lungs and liver, and elsewhere resulting in foreign body granulomas, a special type of tissue reaction to insoluble foreign bodies. Overseas reports even quote such a reduction in the efficiency of lungs that death results from a type of heart failure generally associated, in later life, with atrophy of lung tissue. Eyesight has also been seriously impaired to the point of near blindness.

Another unfortunate result of a prescription for narcotics reaching the hands of the patient is the development of a market either for the prescription itself or of the prescribed tablets. Such a market is often cleverly organised even to the extent of an abuser's non-addicted friend collecting a prescription, not using it, and selling it or giving it to another user. Sale of a relatively unattractive narcotic like methadone to finance a heroin preference is another proven risk.

The ultimate danger, that of self overdose of several doses, of perhaps a week's supply, or more, commonly by intravenous injection with the

grave risk or the occurence of death, is familiar to all who read the daily newspapers.

It has been cynically suggested that as there will be casualties to drug addiction and some inevitable deaths in the groups of those who take drugs, the specific solution would be to allow those who wish to destroy themselves mentally, physically, or socially to do so, by allowing them free access to drugs.

However, there is increasing evidence from countries with a massive drug problem of a possible "maturing out" of dependents as they age over a period of 10 years; Winch found that after age 30 or after 10 years' use the relapse rate was lower. In other situations drug misuse may gradually cease to be the in thing with consequent falling off of its incidence.

The phenomenon of treatment pressure groups is a new factor found in treatment programmes with disorders in which clinical results are poor. It occurs when a resistant condition is being treated and much emotion is generated from the destructive effect of the patients' behaviour on relationships and on the community. This shows up clearly in the field of the treatment of addictions, particularly those involving alcohol and drugs, though certain other family situations are not immune.

In both alcoholism and drug abuse there is considerable rationalisation by the sufferers, and by those close to them, as to certain personality failings, addiction itself, and standards of social behaviour. There is a strong tendency to constant belittling of those therapists who take a rational or pragmatic line and an even more loudly voiced and constant demand that treatment should be along the lines sought or desired by the sufferer, regardless of its effectiveness in real terms. Concomitantly all community rights or expectations are ignored if not condemned.

More is sought for these groups in terms of what their numbers and case may truly require—even if this is to be at the expense of other and therapeutically more favourable disorders widespread in the community. One-way, or exclusive, approaches to such as Synanon or Alcoholics Anonymous are lauded to the exclusion of all others.. Whilst the organisations so singled out for preference may welcome such praises they should be more aware of the very real possibility that unintentionally or unwittingly their efforts may sire "professional ex-addicts" who fit only into those organisations and avoid adaptation into the wider life of the community. Of course, time may well prove that such organisations are the sole long-term refuge for a minority and for these the particular, if exclusive, approach would be supportable. To add unnecessarily to the numbers of such a minority is neither desirable nor supportable, even more so if it is accomplished by using resources much needed elsewhere.

(h) Professor John S. Werry, Professor of Psychiatry, School of Medicine, University of Auckland

Professor McLeod, Dr Culpan, and I feel that as far as the management of the *opiate dependent person* is concerned:

1. There should be specialised "drug-treatment centres" providing residential, day, and outpatient facilities beginning in Auckland.

2. These centres should, where possible, be community based and run (rather than hospital or department) but Government financed, with a mixed medical/patient control along the lines of Wisteria House in Sydney.

In Auckland this centre should not be hospital based and particularly not at Oakley Hospital since the patients would reject such a centre.

3. Opiates other than for analgesic purposes should be prescribed only—

(a) By doctors at a recognised centre;
(b) To a patient who has been properly diagnosed at the centre and registered with issuance of an identity card bearing a photograph and specimen signature.

4. Opiates should be dispensed for other than analgesic reasons only, where in the judgment of a designated centre it would be to the patient's clear advantage (e.g., distance from the centre) to receive it other than in a daily dose administered at the centre, and then only—

(a) From one pharmacy chosen by the patient and notified by the centre, this notification to define the frequency of dispensing (e.g., daily);
(b) When collected personally by the patient;
(c) Upon production of the identification card;
(d) When signed for by the patient.

5. Funds for a concurrent evaluation programme and a research programme be included in the budget of the Auckland centre since it would be the largest.

6. The drug squad of the police force be given a mandate to concentrate its efforts on eradicating the illicit importing of opiates into New Zealand and that users be directed to the centre, not the courts.

12 November 1971.

APPENDIX XIV

LIVING WITH DRUGS

By C. R. Henwood, Victoria University of Wellington

During man's first days on earth as a social animal, he must have come across the plants and roots in nature that gave relief from physical suffering. This would have happened during his search for food resources in his immediate environment. Over many years, the knowledge of different natural remedies would accumulate and it is in these days before man was literate that we see the beginning of drug use.

Apart from the drugs offering relief from physical pain, early man must also have discovered the drugs of a dream nature. Plants that when eaten would provide a release from his immediate surroundings and allow periods of euphoria, hallucination, or intoxication. We tend to think that boredom is a product of modern man but it is more than likely that primitive man suffered longer and more intense periods of boredom than his modern counterpart and the use of the substances of "release" would be widespread.

The development since the early days of these two types of drugs follows two separate paths, meeting only in 1952 with the development of the tranquillisers.

Taking the physical drugs first, we see in primitive tribes the emergence of the witch doctor. He would have his power due to the fact that he could catalogue in his mind the plants around the tribe better than anyone else. He could dispense relief (sometimes) by using this knowledge and was thus thought to have magic powers. This magical connection between drugs and man remained with him until the late Middle Ages.

Leaping forward to the days of Greek and Roman societies, we see the emergence of the doctor figure. The man living within a strict code of professional behaviour and responsible for the health and well-being of the rest of society. He was still, however, confined by the natural environment in his search for useful drugs. He had the knowledge handed down over the preceding centuries, which also contained much folklore and often useless material, but with the birth of scientific man we see the slow increase in the number of natural products available.

By the Middle Ages, the idea was well established that it was the *essence* of the plant that man needed to extract and not just ingest the whole plant. This would come about with the slow realisation that some plants had to be used only at a certain time in their life cycle and thus it was obvious that something was being produced in the plant that gave the relief sought. Man was limited in his ability to take this idea further and indeed this isolation of the essence had to wait many centuries.

By the time of the Renaissance, two figures had emerged in the medical field. Together with the doctor, responsible for the treatment of sickness, we see the rise of the apothecary or alchemist. Here was a man more interested in the search for drug preparations than in their actual use. With this specialisation of interest we see the number of

natural preparations increasing but at the same time the inclusion of much that was useless. Also, the form of the preparation still left much to be desired. When one looks back at the early pharmacopoeia it becomes obvious that the patient had to be remarkably fit to take some of the preparations. However, by the end of the seventeenth century the pharmacist had emerged as a specialist in his own right.

Man had to wait until after the industrial revolution before he attained sufficient scientific sophistication to extract the pure chemicals from the plant material used in medicine. Only in the late 1800s did we see the appearance of aspirin, benzedrine, and the isolation of pure morphine, iodine, and codeine. As late as 1921 it was estimated that 60 percent of all prescriptions written used only three basic drugs—aspirin, phenacetin, and caffeine. Although chemists made a major drive in the field of chemotherapy during the early part of the twentieth century, it was only from 1950 onwards that the exponential rise in the number of drugs occurred following the increased interest in synthetic drugs. No longer is man dependent upon the natural environment directly for his drugs but now tailor-makes chemicals for a specific medical purpose.

Turning now to the development of the "dream" drugs, it is an interesting fact that all societies seem to have developed with at least one drug of intoxication. Early man must have discovered the different mushrooms and other plant life that yielded drugs of the hallucinatory or euphoric type. The history of these drugs shows, however, that their control within a society was governed by different factors. This control came more from socio-religious guidelines and in the main became an *accepted* part of life more than the drugs of a physical nature. Many of them were associated with religious rites and would be used by the medicine man or priest figure only on certain high days and holidays. Slowly over the years each society has grown with its national poison and today different cultures approach each other's dream drugs with suspicion and much emotional bias.

The drug in question for Western society is of course ethyl alcohol. We know that man was using this before he was literate. The "Blue Monument" in the Louvre, the oldest monument to human culture, mentions beer as a drink offering. Throughout Western man's development the drug has been widely used with little apparent need for control. However, of more recent times the misuse of the drug has led to quite strict control by legislation. Anyone familiar with the works of Dickens will have a clear picture of what poor social conditions can do to a mass of people. Following such times it was popular to blame the "demon drink". We are now slowly realising that it is the "demon conditions" (both real and as perceived by misusers) that cause the major misuse of a drug in society. This is further borne out by the fact that in New Zealand in 1911, we came within 0.5 percent of prohibiting alcohol completely following the "wet-dry" vote. This was at a time of economic depression and the highest incidence of drunkenness the country has known. Today we can talk of opening the public houses until 11 or 12 o'clock at night.

We would be fooling ourselves, though, if we think we have solved the problem of the use of alcohol in society. We have in New Zealand an estimated 30,000 alcoholics. But at last we are facing up to the responsibility of treatment for such a condition and the idea of

alcoholism being a sign of moral degeneracy is being replaced by the recognition of it as a disease. We must realise that we know so little about addiction but what we do know points to the areas of personality defect and not the inherent properties of drugs themselves. Thus we must accept that we will never produce a society without drug addicts and, in the case of our particular society, without alcoholics. We must achieve a situation where the drug is used and controlled in the best possible way, while at the same time the people who cannot handle it are given suitable treatment and guidance.

Turning now to a drug of another culture—marijuana. Many years ago, Arabs could only drink alcohol on pain of death because the Koran was very strict on this point. Yet they had a drug of an intoxicating nature—marijuana, obtained from the cannabis plant. Today we can use marijuana on pain of probation, fine, or, exceptionally, up to 3 months' imprisonment yet we can drink ourselves to death. A phenomenon which is by no means uncommon.

Marijuana was known to the Chinese about 3,000 years ago. It entered Western civilisation in the early nineteenth century when Beaudelaire and the Bohemians of Paris met to discuss the effects of the drug. Beaudelaire's book *Paradise Artificiels* describes fully the effect of the drug. Even today much of Beaudelaire's description still holds, though more is known of the clinical effects of short- and medium-term use, and research is actively proceeding with some disturbing pointers yet to be proven.

The question always asked when marijuana is discussed is "What are the harmful effects of the drug?". Yet is this a relevant question when determining whether or not society should have access to it? There are two main reasons why I think not. One is the fact that if you give a scientist any substance he will find it "harmful" to some degree: if you drink too much water you will drown. Secondly, we are too inconsistent on this point of the possible harm caused by drugs. Because if harm to an individual is of paramount importance, then we should have acted more vigorously upon cigarette smoking of tobacco at least 3 years ago.

The question of living or not living with new drugs from another culture will not be answered for us solely by the scientists. It must be seen largely as a social problem and one demanding our fullest attention. Unfortunately, up to now we have not given this problem our *fullest* attention. We have been content to sit back and allow one institution of our society to try and shoulder too much of the burden viz, the law. This is not to deny that the law has a proper role, for some controls are necessary and inevitable.

These two streams of drug development—the mental and physical—came together only in 1952. Work on the rauwolfia alkaloids produced the major tranquillisers. Subsequent work in the field expanded the availability of such drugs and for the first time the doctor had in his armoury a weapon to fight "depression". I think it is now evident that no one was prepared for the enthusiasm with which these new drugs were received. Apart from their use in the treatment of severe mental disorders, the general practitioners in most Western countries now dispense the tranquillisers by the millions of doses per year. In New Zealand during 1969 the Department of Health statistics show that 69 million doses of 2 minor tranquillisers were dispensed.

It is here that we come to what I maintain is our real drug problem. Not the *use* of such drugs by a large section of society but the inability to face up to the fact that the age of chemical man has dawned. We have a bright technological future with chemicals but only if we resolve in our minds the best way to overcome the problems posed by a small percentage of people who cannot handle the use of drugs. The time has come to see the problem of drugs in truer perspective and to ask more persistently the basic question "Why do people take drugs?" Why do some people become addicted—or mastered by drugs—and a majority escape such servitude?

What we must work towards is a system in which *all* problems posed by the use of drugs are handled by the medical and social welfare organisations. A system which treats all drugs in an equitable way. This is not a call for a permissive attitude to drugs but rather a call for a better system of real control over drug taking of all forms.

NOTE—The views expressed in this appendix are not necessarily those of the committee.

APPENDIX XV

STORAGE OF DRUGS

All drugs should be stored in a safe place, especially out of reach of young children. There are, however, legal requirements for the storage of drugs that are poisons or poisonous substances. They must not be kept in any cupboard, box, shelf, or other place of storage in which articles of food or drink are stored or kept for ready use, or in any place to which young children or unauthorised persons have ready access. The majority of therapeutic drugs would come within these categories and must be kept, therefore, in a place specially allotted to them. Any person in possession, for the purpose of sale or for use in his profession, of a drug that is available only on the prescription of a medical practitioner, dentist, or veterinary surgeon, must not leave the premises in which the drug is stored without having taken all reasonable steps to secure the premises against unlawful entry.

In the case of narcotic drugs, even more stringent requirements are imposed. Narcotics must be kept in a locked cupboard of substantial metal construction, or in a locked compartment which, in the case of a building, must be constructed of metal or concrete or both. The cupboard or compartment must be securely fixed to, or be part of the building, ship, aircraft, or vehicle within which the narcotic is kept, and when not in use, the key of the cupboard or compartment must be kept in a safe place. Premises or vehicles in which narcotics are stored must not be left unattended unless all reasonable steps have been taken to secure them against unlawful entry. The key to the narcotic cupboard must be removed to some other place of safe keeping and not left on the premises.

Destruction of Obsolete Narcotics

From time to time, by reason of deterioration, obsolesence, or otherwise, the destruction of narcotics held in retail or hospital dispensaries is warranted. The procedure has been well known for over 30 years, and records indicate that it has been used since before responsibility devolved from Customs Department to Department of Health in 1928.

As far as possible, destruction should be done in the dispensary at the first opportunity by the pharmacist, or in the case of hospital, by the pharmacist in charge, together with an officer from the Department of Health, usually a public health pharmacist, and the action attested by appropriate (dual signed) entries in the Narcotics Register. The nearest medical officer of health will be pleased to arrange for the attendance of a departmental officer in all situations when narcotics are required to be destroyed.

Until disposed of, unwanted narcotics must be kept under the same strict recording and security that applies to serviceable drugs, and not transferred to space set aside for redundant or seldom-used stores.

APPENDIX XVI

INTERDISCIPLINARY SEMINARS ARISING FROM RECOMMENDATION 12 OF FIRST REPORT

(a) Summary of Proceedings

The first report of the Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand recommended in recommendation 12, that the Department of Health arrange seminars involving workers from varied disciplines to discuss mutual problems, co-operation, and education in the broad field of drug dependency and drug abuse. In accordance with this recommendation, three residential seminars were organised by the Department of Health. The seminar director was Mr T. H. J. Austin.

Seminars were held at Templeton Hospital, near Christchurch on 4 and 5 November 1970; at Porirua Hospital, near Wellington on 9 and 10 November 1970; and at Ravensthorpe Hospital, near Auckland on 12 and 13 November 1970.

To meet the objectives of the Board of Health Committee particular care was taken in inviting to the seminars representatives of the widest possible range of social and community services and disciplines to ensure that the maximum benefit could be gained from the exchange of ideas and information. Particular care was also taken in the selection of the principal speaker for the seminars to ensure a range of viewpoints and expertise. Dr W. E. Lucas, MB., BS., Senior Lecturer in forensic psychiatry at the University of Sydney's Institute of Criminology was brought to New Zealand specifically to address each seminar. Other leading speakers, and seminar members are listed in (b) of this appendix.

The seminars fulfilled two valuable roles. There was the residual benefit of improving co-ordination in the analysis and handling of problems of drug dependency and drug abuse in the districts where the seminars were held, through the interchange and with dissemination of ideas and information by those attending.

Perhaps more importantly the seminars revealed a considerable uniformity of opinion of particular aspects of the problems of drug dependency and drug abuse in New Zealand. Since there was a marked dissimilarity, in geographic and demographic terms, in the districts where each seminar was held this localised uniformity of opinion, in certain respects, could reasonably be interpreted as reflecting general community standards in outlook in this field.

Each seminar followed the same pattern. There was a series of addresses by the principal and leading speakers, each of which was followed by a group discussion. Seminar members were then divided into three groups, each of which studied three basic hypothetical questions. The findings of each group were reported to the seminar as a whole and a further discussion was then held. Much of the second day of the seminars was taken up with the consideration of an education programme for the proper and improper use of drugs. For this topic also the seminars were divided into three groups of members who reported to the seminar as a whole as a basis for further discussion.

Following the addresses of Dr Lucas and the other speakers there was considerable discussion on the growth in the usage of illegal drugs in New Zealand as reflected by police and other statistics. In particular the apparent growth in the usage of opiates (including heroin) provoked some concerned comment. Seminar members agreed there had been a sudden upsurge in the use of marijuana in New Zealand since 1967. But apart from an example quoted by Professor A. J. W. Taylor, where two of six known peddlers of marijuana were also distributing heroin there was no evidence that users of marijuana were involved with the criminal element sometimes associated with heroin and related trafficking. Seminar members felt that in spite of the upsurge in marijuana usage only a very small percentage of the population (in November 1970) was using the drug on anything approaching a regular basis and that a policy of refusing to make the drug more freely available would at least limit the exposure to risk of the community as a whole. Where students were involved in marijuana usage, the seminar members thought the increase in usage could in some measure be directly correlated with the growth of the student social protest movement.

The three basic hypothetical questions studied by the seminar groups were:

(a) If Parliament decided to make marijuana more generally available, subject to controls, what sort of controls would be appropriate; and, what sort of problems might arise?

(b) It is alleged there are middle-aged persons avoidably dependent on prescribed drugs, barbiturates, tranquillisers, appetite depressants, for example. How can this problem be evaluated and best brought to the attention of persons involved, and what measures would be appropriate to reduce this incidence?

(c) The initial third question asked at the Christchurch seminar was changed at the Wellington and Auckland seminars. The Christchurch question was "There is a breakdown in communication between experienced older persons and the younger age groups on social problems including drug abuse. How is this to be overcome?" The question as put at Wellington and Auckland was "what type of treatment facilities are required and what is the place of treatment under statutory provisions".

The greatest degree of uniformity between the three seminars was achieved in response to question (a). Each seminar discussion group recognised and stressed that all comments were made on a wholly hypothetical basis. They assumed that marijuana would be widely available, and examined limitations and requirements which were considered appropriate (such as quality control, limitation of general availability to children). They concluded it was quite impracticable to make marijuana widely available yet subject to strongly deterrent or desirable controls. This reaction to marijuana being made more widely available was of particular interest to the Board of Health Committee, emphasising as it does the concern of persons actively involved in dealing with or concerned about current problems of drug dependency and drug abuse.

In response to question (b) it was generally agreed by seminar members that a dependence on prescription drugs may well be unavoidable in certain cases, such as when a person needs specific drugs to function adequately in the face of increasing disabilities and no other appropriate mode of treatment is practicable. Seminar members found it difficult to decide on reliable ways of evaluating the problem of persons avoidably dependent. It was suggested one way of evaluating the problem would be identification of persons unnecessarily dependent on drugs with a view to understanding their motivations and dynamics so that possible alternatives to dependency or drug could be offered with some purport of acceptances. The means of identifying these persons formed much of the discussion on this question, while the respective responsibilities of doctors and pharmacists was also discussed at some length.

Question (c) as asked at Christchurch, through no fault of the members of the Christchurch seminar, had no directly significant relevance to the overall theme of the three seminars. It was generally agreed that a "generation gap" in outlook and attitudes of some sort is within the norm, has always and will seemingly always exist. It was agreed that any better communication between the age groups should result in freer exchanges and more understanding about the uses and misuses of drugs at all age levels.

The Wellington and Auckland seminars in their discussions of question (c), as it was put to them, first considered the type of treatment facilities already available. While mention was made of educational programmes and services conducted by special clinics such as the Alcoholism and Drug Addiction Centre, the National Society on Alcoholism, student counsellors, and some church groups, it was found that the only resources for fuller comprehensive treatment at the time were based on psychiatric hospitals and related hospital outpatient service. The Wellington seminar considered that the greatest need was for more and improved counselling facilities. It was suggested by some that the counselling should be organised along the lines of the Marriage Guidance Counsel. Other facilities worth further study were those along the lines of Synanon and Narcotics Anonymous, but no firm concensus emerged.

On the second day of the seminars members were asked to make suggestions for an education programme for the proper and improper use of drugs. A guide sheet was distributed to each seminar member and the seminar speakers and members of the Board of Health Committee circulated as observers among the groups which were formed to discuss the questions raised. Seminar members generally saw little occasion to deviate from the topics raised in the guide sheet. There was some useful discussion as to how much could be learned or adapted from health education programmes in use overseas. It was generally felt that though something of value could be gained from such programmes, differences in environment and patterns of drug abuse differed so much that any programme for New Zealand would have to be sufficiently flexible to meet the demands of the conditions and circumstances relevant to the country and the time. It was pointed out by Dr Derek Taylor that there would not be just one programme but a number and variety of them. He quoted as examples short-term programmes for the briefing of Customs and police officials and long-term programmes for other sections of the community. The contribution made by seminar

members, both in ideas and in assessments of what is practicable in terms of education programmes, was considerable. This is true also of the seminars as a whole. They fulfilled a useful purpose locally and helped the Board of Health Committee considerably in their assessment of a variety of outlook related to some of the matters covered by this report.

Since the seminars were held the Department of Health has issued a handbook for health educators under the title *Use and Abuse of Drugs.* The Department of Education, in collaboration with the Department of Health, has completed a complementary production intended for use of Forms 1–6 in schools, the text of which was made available to visiting members of the United States National Commission on Marihuana and Drug Abuse when they were in New Zealand.

Both the publications referred to are the forerunners of further material, that for health educators being currently in preparation. Close liaison is being maintained with the Commonwealth Department of Health, Canberra, and with the health departments of certain Australian states, particularly New South Wales and with Federal and Provincial Departments of Public Health of Canada and the Department of Health for England and Wales and Home and Health Department of Scotland. Likewise, close touch is being kept with appropriate organisations within WHO and UNESCO charged with United Nations responsibilities in the field of the control of drug abuse with particular reference to social, health, and educational aspects.

(b) Seminar Members

Christchurch Seminar Members

Dr J. M. Begg, Medical Officer, Sunnyside Hospital.
Dr L. H. Brett, Acting Medical Superintendent, Cherry Farm Hospital.
Mr W. J. A. Brittenden, Principal, Aranui High School.
Mr L. A. Brown, District Probation Officer, Department of Justice.
Mr J. C. Crookston, Constable, Drug Squad, C.I.B.
Mr E. S. J. Crutchley, Senior Stipendiary Magistrate, Department of Justice.
Dr J. R. E. Dobson, Department of Psychological Medicine, North Canterbury Hospital Board.
Miss R. J. Donald, Medical Social Worker, Southland Hospital Board.
Mr A. J. Fraser, Inspector of Secondary Schools, Department of Education.
Dr B. Glennie, Senior Medical Officer, Department of Health.
Rev. M. J. Goodall, City Missioner, Christchurch.
Mr L. B. Harder, Superintendent, Paparua Prison.
Dr Janet Irwin, Student Health Service, University of Canterbury.
Dr L. F. Jepson, Medical Officer of Health, Department of Health.
Mr D. P. Kaperick, Psychiatric Social Worker, Otago Hospital Board.
Mr M. W. J. Lowen, Assistant Head Nurse, Cherry Farm Hospital.
Dr J. M. O'Brien, Medical Practitioner, Christchurch.
Mr D. Riley, Psychology Department, University of Canterbury.
Detective Chief Inspector B. Wilkinson, C.I.B., Christchurch.

Wellington Seminar Members

Mr C. N. Coldicutt, Assistant District Officer, Department of Maori and Island Affairs.
Mr N. G. Cook, Constable, Drug Squad, C.I.B.
Mr K. Daniels, Student Counsellor, Massey University.
Mr W. Garrett, Superintendent, Wi Tako Prison.
Mrs M. Gilmore, Wellington.
Dr A. Guinea, Medical Officer of Health, Lower Hutt.
Dr J. B. Lovell-Smith, Medical Secretary, Medical Association of New Zealand.
Dr D. G. McLachlan, Director, Psychiatric Unit, Wellington Public Hospital.
Miss N. McMaster, Principal, Wellington East Girls College.
Mr B. M. Manchester, District Child Welfare Officer, Department of Education.
Mrs R. N. Manchester, Director, Social Work Training Centre, Porirua Hospital.
Mr A. F. Orr, District Probation Officer, Department of Justice.
Mr P. J. Reid, Executive Director, National Society on Alcoholism.
Mr W. Rogers, Charge Nurse, Porirua Hospital.
Miss R. Swatland, Student Counsellor, Victoria University of Wellington.
Mr C. K. Taylor, Inspector of Secondary Schools, Department of Education.
Dr G. A. Wall, Member of Parliament, Porirua.

Auckland Seminar Members

Dr N. T. Barnett, Medical Officer of Health, Department of Health.
Mr O. Bracey, Senior Probation Officer, Department of Justice.
Mr J. R. Drummond, Senior Stipendiary Magistrate, Department of Justice.
Mr K. J. Flint, District Child Welfare Officer, Department of Education.
Mrs E. Holdgate, Supervisor, Extra-Mural Hospital, Auckland Hospital Board.
Mr G. S. Hurley, Deputy Superintendent, Mount Eden Prison.
Mr J. Johnstone, Charge Nurse, Kingseat Hospital.
Dr J. S. B. Lindsay, Physician in Charge, Department of Psychological Medicine, Auckland Hospital.
Miss D. W. McCauley, Constable, Drug Squad, C.I.B.
Mrs McCoskey, Alcoholism and Drug Addiction Information Centre.
Miss C. McPhail, Case Worker Designate, National Society on Alcoholism.
Miss J. Mahoney, Medical Social Worker, Waikato Hospital.
Mr A. D. Morrison, Inspector of Secondary Schools, Department of Education.
Mr R. G. Oliver, Inspector of Secondary Schools, Department of Education.
Dr M. Pearl, Student Health Service, University of Auckland.
Mr J. M. Print, Principal, Penrose High School.
Mr N. P. K. Puriri, Assistant Controller, Maori Welfare, Department of Maori and Island Affairs.
Major Thelma Smith, Social Services, Salvation Army.
Dr W. R. Trotter, Medical Practitioner, Auckland.

APPENDIX XVII

STATISTICAL FIGURES

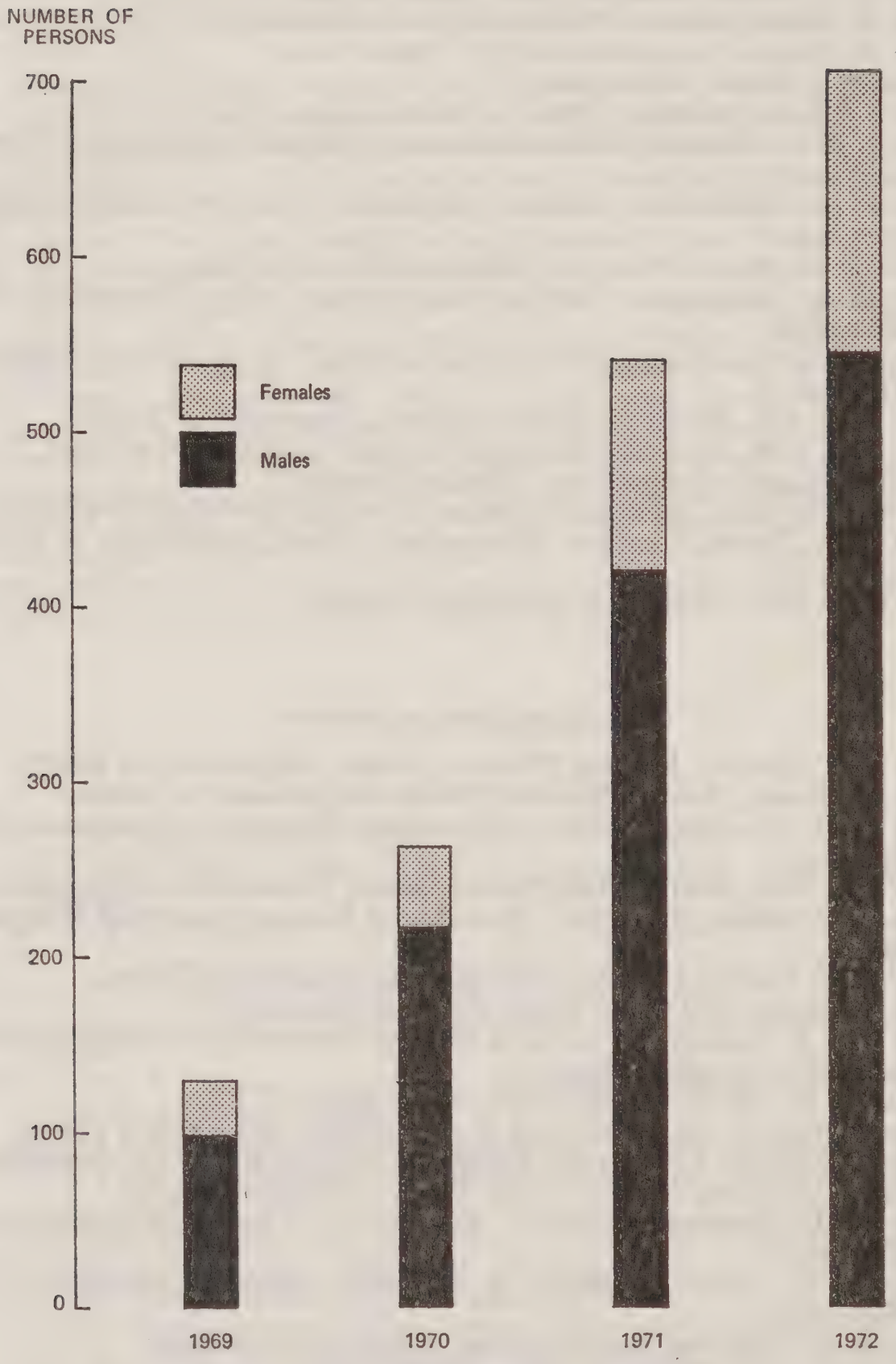

Fig. 1—Persons charged with drug offences, 1969–72

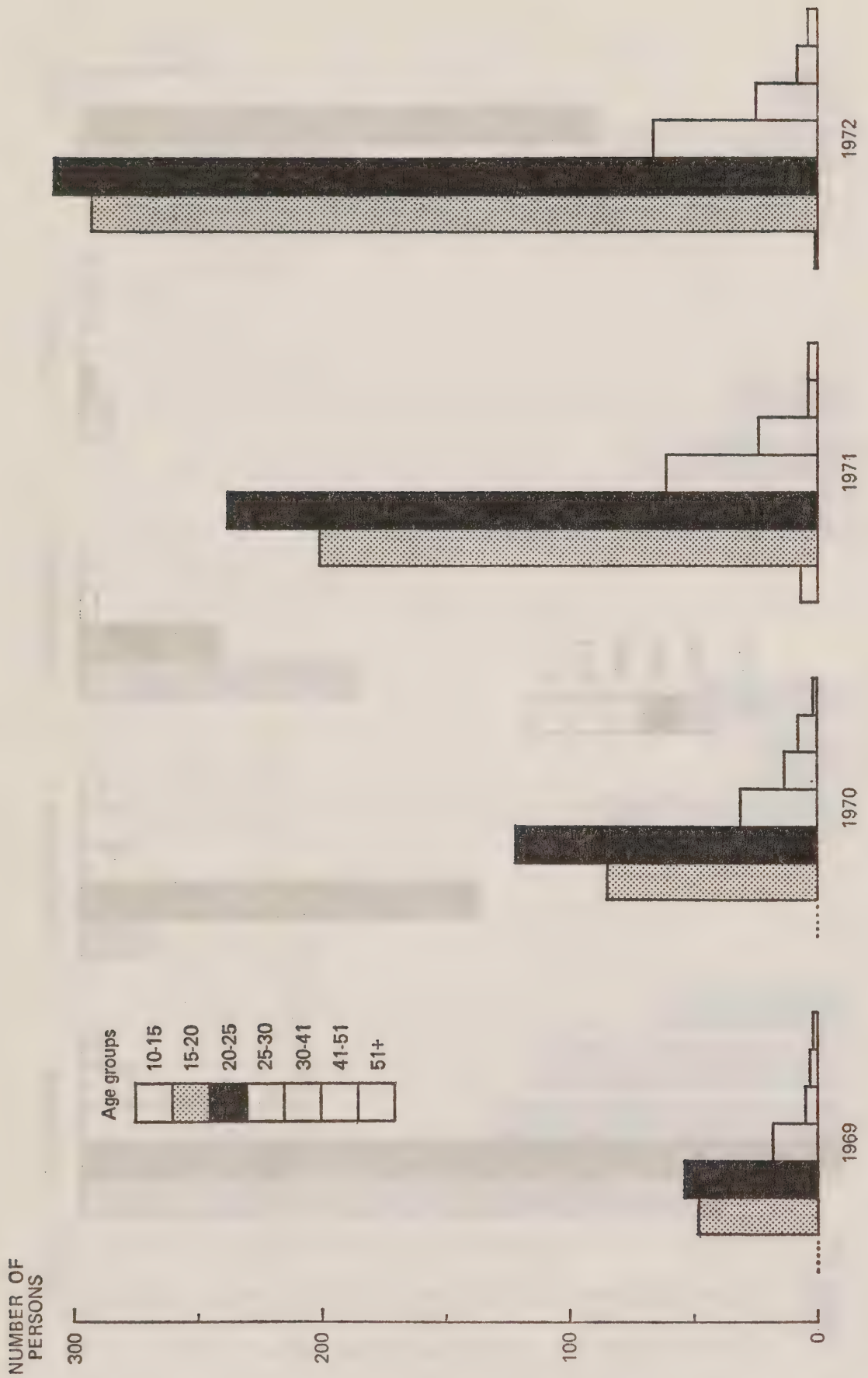

Fig. 2—Persons charged with drug offences, by age group, 1969–72

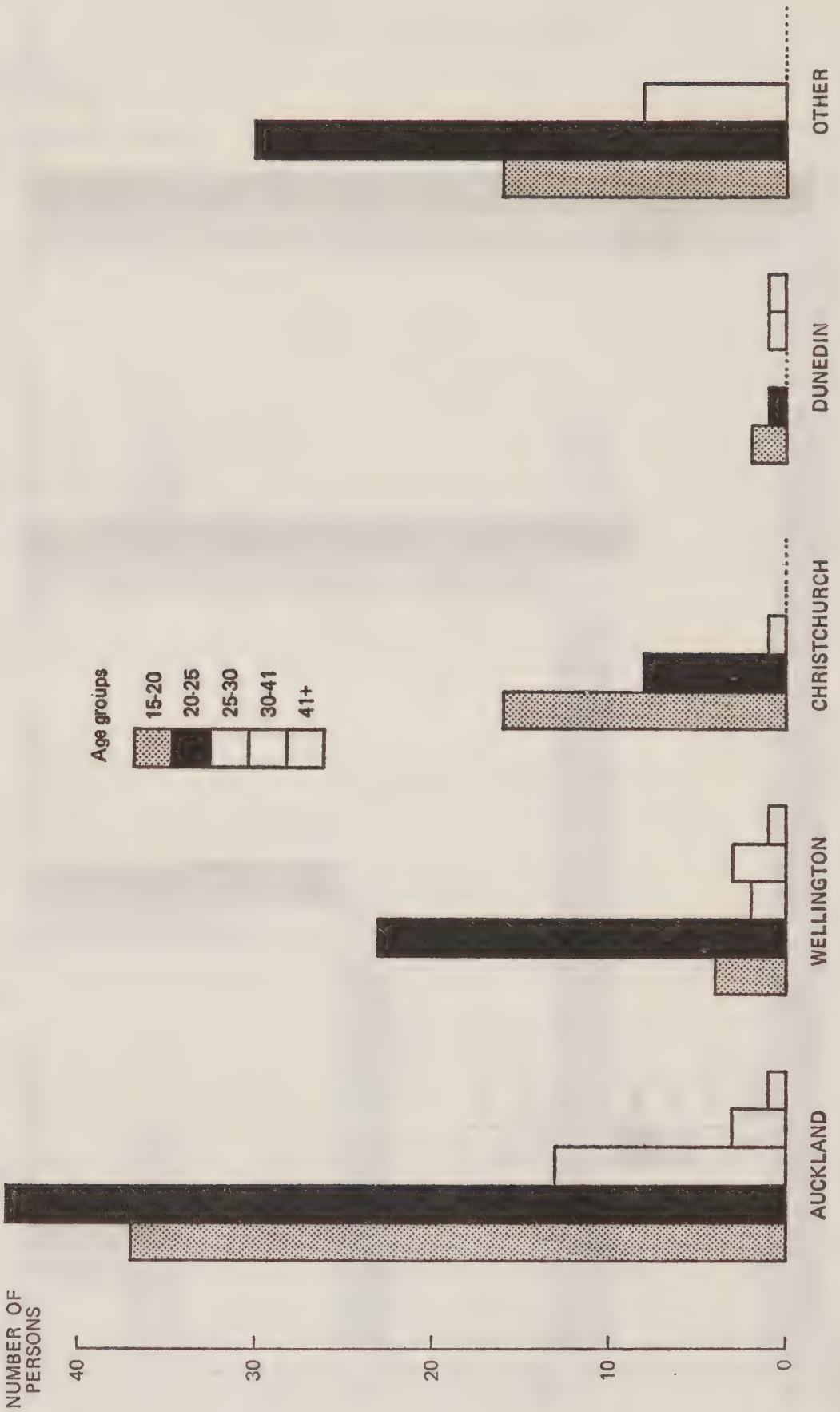

Fig. 3—Persons charged with drug offences in last quarter of 1972, by district and age group

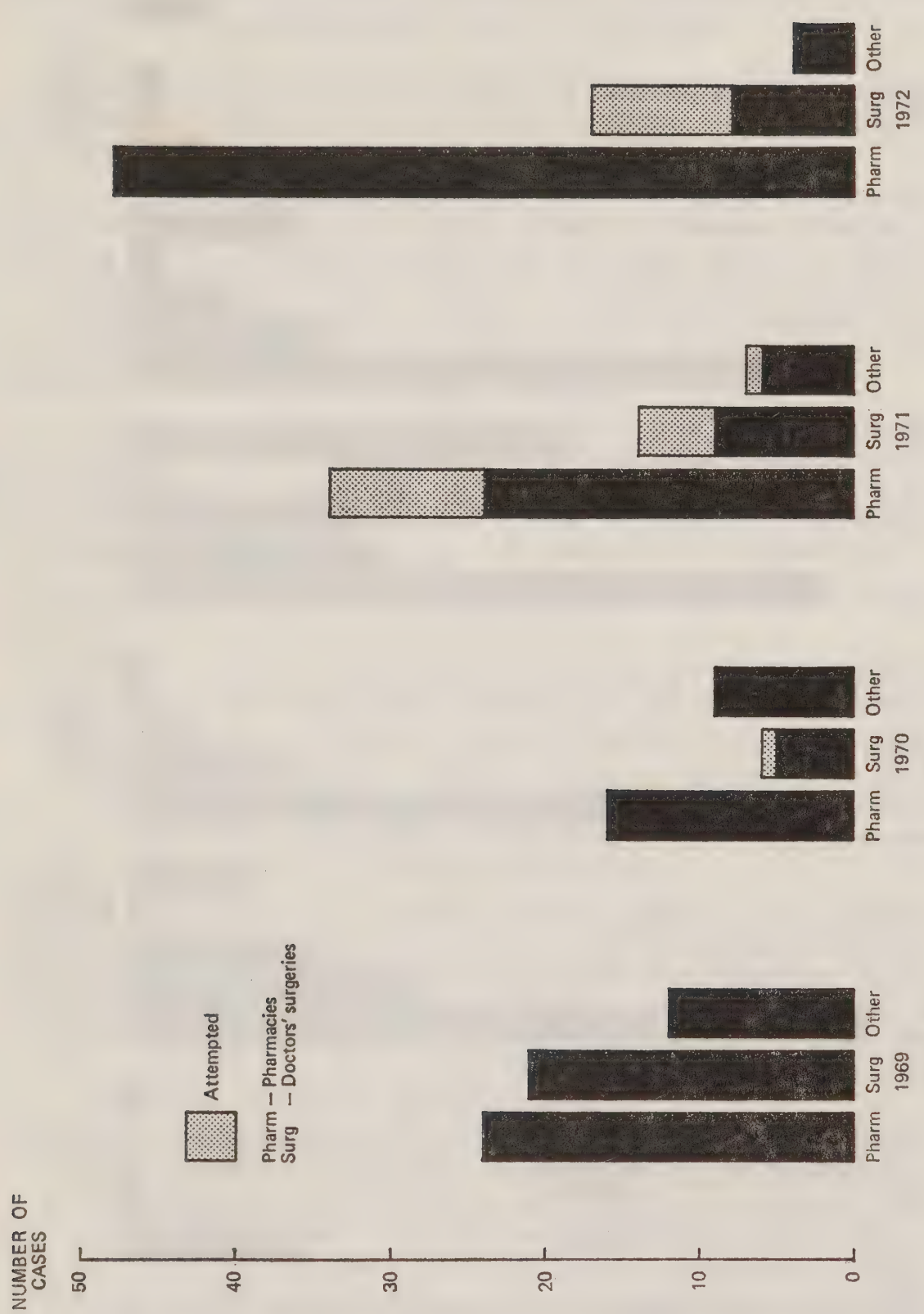

Fig. 4—Burglaries and thefts of drugs, 1969–72

Fig. 5—Drugs involved in charges during 1972, by district

APPENDIX XVIII

EXTRACTS FROM THE NARCOTICS REGULATIONS 1966, AMENDMENT NO. 4, 1973/100

7. Treatment of persons dependent on narcotics—The principal regulations are hereby further amended by inserting, after regulation 25, the following regulation:

"25A. (1) In this regulation, and in regulation 26 of these regulations, 'dependent' means being in a state of periodic or chronic intoxication, produced by the repeated consumption or other use of a narcotic detrimental to the person in relation to whom the word is used, and involving a compulsive desire to continue consuming or otherwise using the narcotic or a tendency to increase the dose of the narcotic; and 'dependency' has a corresponding meaning.

"(2) Except as provided in subclauses (3) and (7) of this regulation, and notwithstanding any other provision of these regulations, no practitioner shall prescribe, administer, or supply any narcotic for or to any person, whom the practitioner has reason to believe is dependent, in the course, or for the purpose of treatment for dependency.

"(3) A medical practitioner may prescribe, administer, or supply any narcotic for or to any such person—

"(a) If he is for the time being a medical practitioner specified by the Minister under subclause (6) of this regulation; or

"(b) While working in a hospital or health centre, within the meaning of the Hospitals Act 1957, or clinic or other similar place, so specified, if he is authorised in writing by a medical practitioner, so specified and working in that hospital, centre, clinic, or place, to prescribe narcotics; or

"(c) In the capacity of a medical officer employed in a hospital, so specified and carried on by a Hospital Board, if he is authorised in writing by the medical superintendent of that hospital, acting under the general or special directions of the principal medical officer of the Board in any case where the medical superintendent is not such principal medical officer, to prescribe narcotics; or

"(d) With the permission in writing of any such specified medical practitioner or authorised medical officer, in relation to a particular patient, for such period and in accordance with such terms and conditions, as the medical practitioner or medical officer may in writing specify or impose.

"(4) Except with the concurrence of the Medical Officer of Health, no permission given under paragraph (d) of subclause (3) of this regulation shall be expressed to apply for any period longer than 3 months, but any such permission may from time to time be renewed by the specified medical practitioner or by the authorised medical officer, or any other medical officer similarly authorised and employed in the same hospital, for a period not exceeding, except as aforesaid, 3 months at any one time.

"(5) Any authority or permission given or renewed pursuant to subclause (3) or subclause (4) of this regulation may, by notice in writing to the person to whom the authority or permission was given, be withdrawn at any time by the person who gave or renewed the authority or permission, and shall be deemed to have been so withdrawn when the notice specifying the hospital, health centre, clinic, or place, in or from which the authority or permission was given or renewed, or specifying the medical practitioner by whom the authority or permission was given, as the case may require, is revoked, or in the case of an authority under paragraph (b) of the said subclause (3), such medical practitioner dies or ceases to work in the hospital, health centre, clinic, or place to which the authority relates.

"(6) The Minister may from time to time, by notice in the *Gazette*, specify—

"(a) By name, any medical practitioner as a medical practitioner who may prescribe, administer, or supply narcotics for the purposes of this regulation:

"(b) By name or description, any hospital carried on by a Hospital Board, or any hospital, health centre, clinic, or other place, in which a medical practitioner, for the time being specified by the Minister under paragraph (a) of this subclause, works, as a hospital, health centre, clinic, or place at which narcotics may be prescribed, administered, or supplied for the purposes of this regulation;

and may in like manner revoke or amend any such notice.

"(7) Nothing in the preceding provisions of this regulation shall apply to—

"(a) The treatment of a patient, within the meaning of the Alcoholism and Drug Addiction Act 1966, while he is in an institution, within the meaning of that Act:

"(b) The emergency treatment of a patient in any hospital, within the meaning of the Hospitals Act 1957, for a period not exceeding 3 days:

"(c) The treatment of any restricted person within the meaning of regulation 26 of these regulations."

8. Custody of narcotics—Regulation 28 of the principal regulations (as substituted by regulation 8 of the Narcotics Regulations 1966, Amendment No. 2) is hereby amended by adding the following subclause:

"(4) For the purposes of subclauses (1) and (2) of this regulation, 'building' includes a room in a building:

"Provided that a room shall be deemed to be attended—

"(a) In the case of a room forming part of a dwelling (being residential accommodation occupied by 1 person living alone, or by 2 or more persons living together but independently of other persons, if any, residing in or using other rooms in the same building) so long as a person who lives in that dwelling is within that dwelling or on adjacent land occupied or used in connection therewith; or

"(b) In any other case, so long as a person who works in or otherwise uses that room is within another room communicating therewith; or

"(c) If the room, and any room communicating therewith, is not vacated for a longer period than 10 minutes at any one time by all persons working in or otherwise using the room."

11. Duty to supply information—The principal regulations are hereby further amended by inserting, after regulation 34, the following regulation:

"34A. (1) Every practitioner shall answer in writing, to the best of his knowledge and belief, any questions addressed to him by the Medical Officer of Health with respect to his prescribing, administering, or supplying of narcotics and in respect of the identification of the person for whom they were prescribed or to whom they were administered or supplied.

"(2) Every person who supplies a narcotic, otherwise than as a pharmaceutical benefit under the Social Security Act 1964, on the prescription of a medical practitioner, shall, within 1 month after the date of the supply, inform the Medical Officer of Health in writing of—

"(a) The name and address of the person for whom the narcotic is supplied:

"(b) The name and address of the prescribing practitioner:

"(c) The date of the prescription:

"(d) The name or description of the narcotic supplied:

"(e) The amount of the narcotic supplied on the occasion or on each of the occasions of supply:

"(f) Each date on which the narcotic is supplied.

"(3) It shall be sufficient compliance with the requirements of subclause (2) of this regulation, if the person supplying the narcotic provides the Medical Officer of Health, within 1 month after the date of the supply or, if the prescription authorises the supply of a narcotic on more occasions than one, the date of the first supply, with a copy of the prescription to which the supply relates.

"(4) In this regulation 'prescription' includes any written authority, order, or request for the supply of narcotics signed by a medical practitioner, not being an authority, order, or request relating to the provision of pharmaceutical benefits under the Social Security Act 1964 or to a disposal by wholesale within the meaning of regulation 47 of these regulations, and 'prescribing' has a corresponding meaning:

"Provided that paragraph (a) of subclause (2) of this regulation shall not apply to any such authority, order, or request not having reference to a particular patient."

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